THE SELF-PERCEPTION OF CHRONIC PHYSICAL INCAPACITY AMONG THE LABOURING POOR. PAUPER NARRATIVES AND TERRITORIAL HOSPITALS IN EARLY MODERN RURAL GERMANY.

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ABSTRACT

This thesis examines the experiences of the labouring poor who were suffering from chronic physical illnesses in the early modern period. Despite the popularity of institutional history among medical historians, the experiences of the sick poor themselves have hitherto been sorely neglected. Research into the motivation of the sick poor to petition for a place in a hospital to date has stemmed from a reliance upon administrative or statistical sources, such as patient lists. An over-reliance upon such documentation omits an awareness of the 'voice of the poor', and of their experiences of the realities of living with a chronic ailment. Research focusing upon the early modern period has been largely silent with regards to the specific ways in which a prospective patient viewed a hospital, and to the point in a sick person's life in which they would apply for admission into such an institution. This thesis hopes to rectify such a bias.

Research for this thesis has centred on surviving pauper petitions, written by and on behalf of the rural labouring poor who sought admission into two territorial hospitals in Hesse, Germany. This study will examine the establishment of these hospitals at the onset of the Reformation, and will chart their history throughout the early modern period. Bureaucratic and administrative documentation will be contrasted to the pauper petitions to gain a wider and more nuanced view of the place of these hospitals within society. Chapters on family care, old age, and work will evaluate the poor's experience of illness prior to hospitalisation. The overarching theme of this thesis focuses upon the misconception of the poor as passive recipients of relief. Issues such as the way in which the poor coped with their physical infirmities prior to hospitalisation will play a large role in this study.

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CONTENTS

LIST OF ILLUSTRATIONS.

LIST OF ABBREVIATIONS

HJL – Hessiches Jahrbuch für Landesgechichte.

LWV - Archiv des Landeswohlfahrtsverbandes Hessen.

PKH - Psychiatrisches Krankenhaus, Haina.

StAM – Staatsarchiv Marburg.

VHKH - Veröffentlichungen der Historischen Kommission für Hessen.

ZHG – Zeitschrift des Vereins für hessische Geschichte und Landeskunde.

INTRODUCTION

The growth of interest in the social history of medicine in the last couple of decades has led to an increased focus upon the patient within historical studies.[1] The earlier neglect of this topic was summarised in 1967 by George Rosen, when he proposed that 'the patient deserves a more prominent place in the history of medicine'.[2] The vast majority of works relating to the early modern period have stemmed from the 1980s onwards. Following Roy Porter's call to historians over a decade ago, to offer a 'counterweight' to the emphasis on a 'physician-centred account', by focusing on 'a patient-oriented history', 'a sick people's or sufferers' history', research has begun to make great in-roads into this field.[3] Seminal works such as those of Roy Porter, Michael MacDonald and Barbara Duden are indicative of this movement.[4] These studies have been exemplary in showing that it is possible to reconstruct a patient's concept of illness and their relationship with a wide range of healers. Research into medicine 'from below' has prompted many examinations of the 'therapeutic experience'. These have done much to rectify the earlier bias which Roy Porter summarised in 1985, when he complained that we have 'histories of disease but not of health, biographies of doctors, but not of the sick.'[5]

As important as these studies have been in broadening our understanding of illness and medicine in the early modern past, works to date have all too often

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[1] For a brief critique of this movement see Lindemann, Mary, Medicine and Society in Early Modern Europe, Cambridge, 1999, pp. 1 – 5.

[2] Rosen, George, 'People, Disease, and Emotion: Some Newer Problems for Research in Medical History', Bulletin of the History of Medicine, 41, 1967, p. 8.

[3] Porter, Roy, 'The Patients' View. Doing Medical History from Below', Theory and Society, 14, 1985, pp. 167 - 174.

[4] Porter, Dorothy & Porter, Roy, In Sickness and in Health: The British Experience, 1650 – 1850, London, 1988; idem, Patient's Progress: Doctors and Doctoring in Eighteenth-Century England; Stanford, California, 1989; Porter, Roy (ed.), Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society, Cambridge, 1985; idem, 'Patient's View', pp. 175–198; MacDonald, Michael, Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth-Century England, Cambridge, 1981; Duden, Barbara, The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany, translated by Thomas Dunlap, Cambridge, Mass., 1991. (Originally published in German as Geschichte unter der Haut. Ein Eisenacher Arzt und seine Patientinnen um 1730, Stuttgart, 1987.) See also Beier, L. McCray, Sufferers and Healers: The Experience of Illness in Seventeenth-Century England, London, 1987; Sawyer, Ronald, Patients, Healers and Disease in the South West Midlands, 1597 – 1634, DPhil, University of Wisconsin, Madison, 1986.

[5] Porter, Roy, 'Introduction', in Idem, Patients, p. 5.

concentrated upon certain groups of the sick. Attention has usually been restricted to the abundant nature of surviving documentation that deals exclusively with the attitudes of the urban elite and middling classes. Such 'patient histories' inevitably focus either upon the views of the literate and educated elite as evinced in diaries and personal correspondence, or upon an experience of illness as described within the context of a doctor's casebooks. This has led to a distorted representation of the sick in early modern society. The 'voice of the poor' is too often lost in these histories. The available source-base, and frequently the agendas of historians (who often rule out potential sources relating to the poor), have lead to generalisations being made. Accepting the elite and middling perspective of this class, the poor are often falsely spoken of as an undifferentiated mass. As J. Sharpe has commented, 'despite the tendency of their social superiors to describe the common people or groups among them under some blanket term, it remains clear that they were variegated: the lower orders were not merely an undifferentiated and amorphous agglomeration.'[6] An important exception to this focus is Gianna Pomata's study of early modern Bologna that considers the experience of sickness among the poor through the judicial records of the *Protomedico*.[7] Pomata's work concentrates primarily upon the negotiated relationship between patient and a wide range of healers. This thesis is similarly interested in the 'voice of the poor' and the rights that these people thought were due to them. In comparison to Pomata's work, however, the primary focus of this study will be upon the experience of chronic illness among the labouring poor. It will consider how individuals coped with these ailments prior to submitting applications for hospitalisation. It is hoped that this thesis will go someway to dealing with one of the areas that is still largely neglected in medical history – 'to probe the personal and collective meanings of sickness, of suffering and recovery, probing how 'illness experiences' were integrated within the larger meanings of life, from the cradle to the grave.'[8]

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[6] Sharpe, J. A., Early Modern England. A Social History 1550 – 1760, 2nd edition, London & New York, 1997, (1st edition, 1987) p. 205.
[7] Pomata, Gianna, Contracting a Cure. Patients, Healers, and the Law in Early Modern Bologna, London & Baltimore, 1998.
[8] Porter, Roy, 'Introduction', in Idem (ed.), Patients, p. 5.

Within the realm of institutional studies, specific interest in patient history is woefully scarce. Referring to the status of research concerning German hospital history in 1995, Johanna Bleker stated that 'patient-centred studies about hospitals in German speaking areas have hitherto [i.e. prior to the publication of her work] been scarce and in no way cover the whole period of hospital evolution [*Entwicklungszeitraum*]. They focus primarily upon the eighteenth-century or upon the late nineteenth-century.'[9] Bleker's study concentrates upon the period from 1819 – 1829. The same comments are true of the status of research from the sixteenth- to the early eighteenth-centuries in which little reference is made to patients except in statistical and quantitative terms. Exceptions to this rule can be found in the work of Aline Steinbrecher for Zurich, and for Christina Vanja and H. C. Erik Midelfort for Hesse.[10] As

[9]Bleker, Johanna, 'Patientenorientierte Krankenhausgeschichtsschreibung – Fragestellung, Quellenbeschreibung, Bearbeitungsmethoden', in Bleker, Johanna, Brinkschulte, Eva & Grosse, Pascal (hrsg.), Kranke und Krankheiten im Juliusspital zu Würzburg 1819 – 1829. Zur frühen Geschichte des Allgemeinen Krankenhauses in Deutschland, Abhandlungen zur Geschichte der Medizin und der Naturwissenschaften, Heft 72, Husum, 1995, pp. 11 – 23, here p. 12. Bleker illustrates this point by referring to works such as Imhof, Arthur E., Die Funktion des Krankenhauses in der Stadt des 18. Jahrhunderts', Zeitschrift für Stadtgeschichte, Stadtsoziologie und Denkmalpflege, 4, 1977, pp. 215 – 242, which focuses largely on the Berlin Charitè, and Stürzbecher, Manfred, 'Zur Statistik der Krankenhäuser in Preußen im 19. Jahrhundert - Übersicht über die Aufstellungen des Stadtkrankenhauses in Stralsund 1816 – 1880', Historia Hospitalium, 9, 1974, pp. 7 – 19.

[10] Steinbrecher, Aline, 'Schicksal eines psychisch Kranken im 17. Jahrhundert. Ein Zürcher Obervogt verliert den Verstand', Separatdruck aus dem Zürcher Taschenbuch auf das Jahr 1999, Zürich, 1998 (sic), pp. 331 – 361; Idem, '"von der Blödigkeit des Haupts". Geisteskranke im Zürcher Spital 16 – 18 Jahrhundert', Lizentiatsarbeit der Philosophischen Fakultät I der Universität Zürich, Zürich, Mai 1997; Vanja, Christina, 'Gemütskranke als Naturwesen – Pazifizierungsstrategien im Umgang mit psychisch Kranken in der frühneuzeitlichen Gesellschaft', (Vortrag im Rahmen des Internationalen Kongresses "Der Frieden-Rekonstruktion einer europäischen Vision", 25. – 31. Oktober, 1998 in Osnabrück am 30. Oktober, 1998), unpublished paper. I wish to thank Christina Vanja for providing me with a copy of this paper. Vanja, Christina & Ehmer, Hermann, 'Protokoll der Sitzung am 1. März 1997 im Hauptstaatsarchiv Stuttgart. Thema: Frauengeschichte II: Frauen und Wohlfahrt', Arbeitskreis für Landes- und Ortsgeschichte im Verband der württembergischen Geschichts- und Altertumsvereine, Stuttgart, 1997, unpublished paper; Vanja, Christina, 'Madhouses, Children's Wards, and Clinics: The Development of Insane Asylums in Germany', in Finzsch, Norbert & Jütte, Robert (ed.), Institutions of Confinement: hospitals, asylums, and prisons in Western Europe & North America, Cambridge, 1996, pp. 117 – 132; Idem, 'Waren Hexen gemütskrank? Psychisch kranke Frauen im hessischen Hospital Merxhausen', in Johannes Gutenberg-Universität Mainz Ringvorlesungen, Band 6, Sommersemester 1995 – Wintersemester 1996 / 97, Mainz, 1998, pp. 75 – 92; Idem, '"Und könnte sich gross Leid antun": Zum Umgang mit selbstmordgefährdeten psychisch kranken Männer und Frauen am Beispiel der frühneuzeitlichen 'Hohen Hospitäler' Hessens', in Signori, Gabriela (hrsg.), Trauer, Verzweiflung und Anfechtung: Selbstmord und Selbstmordversuche in mittelalterlichen und frühneuzeitlichen Gesellschaften, Tübingen, 1994, pp. 210 – 233; Idem, 'Arme und Kranke aus Kaufungen in den landgräflichen hessischen Hospitälern', in Sergei, Thomas et al (hrsg.), Kaufunger Wald Land und Leute zwischen Fulda und Werra, Kassel, 1992, pp. 17 – 27; Idem, 'Vom Gottesdienst zur Fürsorge – Die mittelalterlichen Hospitäler', in Seibt, Ferdinand et al (hrsg.), Vergessene Zeiten Mittelalter im Ruhrgebiet, Katalog zur Ausstellung im Ruhrlandmuseum Essen. 26 September 1990 bis 6.

important as these works are, it must be noted that the primary motivation behind all of them is a study of the history of madness. In comparison to this thesis, therefore, the emphasis upon the aforementioned studies of mental illness eclipses any interest in the history of the patients' experience of illness per se, and doesn't consider issues relating to poverty.

It is notoriously difficult to re-construct the experiences of the poor themselves. As a predominantly, if indeed not exclusively, illiterate class, their voice can often remain hidden within the realms of surviving documentation. Frequently tantalisingly referred to in sources, only scattered pieces of information can be discovered, usually through administrative records, which give brief details about a person's life, without actually leaving one with any sense of their identity or experiences. One of the main aims of this thesis is to uncover the ways in which the invalid experienced and coped with their infirmities prior to hospitalisation - a concept that is usually ignored by historians of early modern medicine. A discussion concerning the motivation behind a person applying for a place in a hospital will form a central part of this work.

This study examines the experiences of the labouring poor who were suffering from chronic physical illnesses in the early modern period. Despite the popularity of institutional history among medical historians, the perceptions of the sick poor themselves have hitherto been sorely neglected. Overwhelmingly, hospital histories to date have either focused upon the organisation of a specific institution, or have considered such foundations within a wider historical agenda, particularly with regards to debates concerning Foucault and the medicalisation

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Januar 1991, Band 2, pp. 192 – 196; Idem, 'Disabled and insane people in early modern Christian hospitals', in Fierens, Eric et al (ed.), Proceedings of the XXXIInd Internal Congress on the History of Medicine, Antwerp, 3 – 7 September, 1990, Antwerp, 1990, pp. 855 – 858; Idem, 'Armut und Krankheit, Disziplinierung und Fursorge. Aus den Beständen des Archivs des Landeswohlfahrtsverbandes Hessen', Jahrbuch '89. Landkreis Kassel, Kassel, 1989, pp. 149 – 151; Midelfort, H. C. Erik, 'Protestant Monastery? A Reformation Hospital in Hesse', in Brooks, Peter Newman (ed.), Reformation Principle and Practice. Essays in Honour of Arthur Geoffrey Dickens, London, 1980, pp. 71 – 94; Idem, 'Sin, Melancholy, Obsession: Insanity and Culture in 16th Century Germany', in Kaplan, S. L. (ed.), Understanding Popular Culture, Berlin, 1984, pp. 113 – 145; Idem, A History of Madness in Sixteenth Century Germany, Stanford, 1999, pp. 332 – 385.

process.[11] While a few previous works have considered daily life within a hospital setting (*Alltagsgeschichte*), prior research into the motivation of the sick poor to petition for a place in a hospital has stemmed from a reliance upon statistical sources, such as patient lists, or upon the foundation ordinances which stipulated for whom the hospital was intended to cater.[12] It is the contention of this thesis that an over-reliance upon such documentation omits an awareness of the 'voice of the poor', and of their understanding of the realities of living with a chronic ailment. Where studies to date have considered patient experience, it has predominantly been through bureaucratic records concerning complaints and punishments, and has frequently relied on second-hand comments written by an official or administrator. Research focusing upon the early modern period has been largely silent with regards to both the specific ways in which a prospective patient viewed a hospital, and the point in a sick person's life in which they would apply for admission into such an institution. Such a dearth of interest can be compared to the growing number of studies which relate to applications for poor relief and which concentrate upon the role of this aid within life-cycle strategies. A common theme of such investigations concerns the power that the poor applicants potentially revealed through these documents.[13] Questions focus

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[11] Foucault, Michel, The birth of the clinic: an archaeology of medical perception, translated by Sheridan Smith, A. M., London. 1973; Idem, Madness and civilisation: a history of insanity in the Age of Reason, translated from the French by Richard Howard; London, 1967. For a critique of Foucault's ideas, see Dinges, Martin, 'Michel Foucault's Impact on the German Historiography of Criminal Justice' in Finzsch & Jütte, Institutions, pp. 155 – 174; Porter, Roy, 'Foucault's Confinement', History of the Human Sciences, Volume 3, Number 1, 1990, pp. 47 – 54. See also the collection of essays, Jones, Colin & Porter, Roy (eds.), Reassessing Foucault: Power, Medicine and the Body, London & New York, 1994.

[12] Regarding *Alltagsgeschichte*, see Knefelkamp, Ulrich, Das Heilig-Geist-Spital in Nürnberg vom 14 – 17 Jahrhundert: Geschichte, Struktur, Alltag, Nuremberg, 1989; Mayer, Marcel, Hilfsbedurftige und Delinquenten: Die Anstaltsinsassen der Stadt St. Gallen 1750 – 1789, St. Galler Kultur und Geschichte 17, St. Gallen, 1987; Mischlewski, Adalbert, Alltag im Spital zu Beginn des 16. Jahrhunderts, in Kohler, Alfred (hrsg.), Alltag im 16. Jahrhundert: Studien zu Lebensformen in spatmittelalterlichen Städten, Wien, 1987, pp. 152 – 173. See also the comments of Ann Goldberg: 'Institutionalizing Female Sexual Deviancy: Women, Rural Society, and the Insane Asylum in Nassau, 1815 – 1849', in Blänker, Reinhard & Jussen, Bernhard (hrsg.), Institutionen und Ereignis: über historische Praktiken und Vorstellungen gesellschaftlichen Ordnens, Göttingen, 1998, pp. 275 – 294, here p. 276. Regarding the problems of an over-reliance upon censuses as a source-base, see Chaytor, Miranda, 'Household and Kinship: Ryton in the late 16th and early 17th centuries. Sources and Problems', History Workshop Journal, 1980, pp. 25 – 60, here pp. 26 – 27.

[13] Sokoll, Thomas, 'The position of elderly widows in poverty. Evidence from two English communities in the late eighteenth and early nineteenth centuries', in Henderson, John & Wall, Richard (ed.), Poor women and children in the European past, London & New York, 1994, pp. 207 – 224. See also other essays in this volume, and in the following collection: Hitchcock, Tim, King, Peter, & Sharpe, Pamela (ed.), Chronicling Poverty: the voices and strategies of the

on issues such as whether and how these individuals were able to manipulate the poor relief process to most benefit themselves. No thorough study relating to medicine and hospitalisation from the sixteenth- to the early eighteenth-centuries exists to date.[14] This study hopes to rectify such a bias.

In short, the main aim of this inquiry is to break with the traditions prevalent in early modern histories in a number of important ways, as outlined above. By looking at the petitions of poor people to enter the 'state hospitals' (*Landesspitäler*) of Haina and Merxhausen, situated in rural Hesse, Germany, I will seek to offer some insight into the experience of illness among the poor in the early modern period.[15] I thus hope to break the silence which is usually afforded to these classes in historical study, and to offer a subtler analysis of the way in which early modern people understood and dealt with chronic physical conditions than has hitherto been acknowledged in examinations of medical care.

I. Source Base.

The research for this thesis has centred upon a wide range of surviving sources relating to Haina and Merxhausen hospitals. Administrative and bureaucratic documents detailing the establishment and running of the hospitals – sources that usually form the core of hospital histories – will be consulted. With the Haina and Merxhausen archives, we are in the fortunate position of being able to

English Poor, 1640 – 1840, London & New York, 1997, pp. 1 – 18; Snell, Keith, Annals of the Labouring Poor. Social Change and Agrarian England, 1660 - 1900, Cambridge, 1985.

[14] One possible exception to this is the doctoral thesis by Geoff Hudson, which focuses on the English County Pension Scheme and looks, in part, at how ex-servicemen and war widows tried to work this scheme to their advantage. (Hudson, Geoff, Ex-Servicemen, War Widows and the English County Pension Scheme, 1593 – 1679, DPhil, University of Oxford, 1995.) While some of the wider themes correspond to areas that we are concerned with here, Hudson's approach is very different. He does not address the issue of self-perception or experience – interests that are central to this thesis – and he focuses primarily upon the establishment of this pension scheme.

[15] Throughout the period under study here, the terms *Landesspitäler* and *Landeshospitäler* were frequently interchanged. It must be noted that throughout this thesis, German words will appear as they are written in the documents consulted – and thus may be spelt differently to modern German spellings. Moreover, the spellings of certain words varied greatly, depending upon which document one consults. Upon occasion, more than one spelling of a single word appears within one document.

consult the thousands of hospital petitions (*Reskripte*) that have survived.[16] In order to obtain a sufficiently wide number of these appeals, sources from the second half of the sixteenth-century until approximately 1725 will be considered. This correspondence, written by and on behalf of the rural labouring poor who sought admission into these institutions, will form the primary focus of this study. Before turning to a discussion of the territorial hospitals (*Landesspitäler*), a critique of these written testimonies must first be offered and several key issues must be addressed.

The specifically localised nature of this Hessian source material must constantly be borne in mind. This investigation aims to provide a broad contextual analysis and to offer comparisons, where appropriate, to situations elsewhere in Europe during this period. The thesis will also endeavour to avoid the pitfalls of reaching any sweeping conclusions about the state of early modern medicine as a whole from the evidence unearthed. After all, not only is the documentation related specifically to Hesse, but it also concentrates upon two specific institutions whose individual nature will obviously have had a bearing both upon the types of people who sought admission to these hospitals and, by default, upon the entrance process itself. When, for example, we are referring to the 'sick poor' with regards to the hospital petitions, it must be remembered that we are dealing with a particular section of these persons. The focus of this thesis will largely restrict itself to a small percentage of the labouring poor of the Hessian countryside – the incurably sick whose petitions were, in theory at least, accepted by the ruling Landgrave. This study is thus neither about the 'ordinary person' nor about the 'poor' in an all-encompassing sense. Neither could it expect to be. Such definitions of categories are problematic at the best of times and require careful use, if one is to avoid treating this group as an undifferentiated mass. In spite of these considerations, this investigation will go some way to offering a balance to previous studies that have concentrated upon the urban middle and upper classes.

[16] For more information, see Vanja, 'Armut', p. 149; Idem, 'Madhouses', p. 120. *Reskripte* can also be spelt *Rescripte*. For the purposes of this, the former spelling will predominate.

Although work on pauper petitions has recently undergone resurgence in both medical and social history, most studies have been based upon English sources.[17] While topics relating to a variety of aspects of 'village communication' are enjoying attention in German cultural historiography, this topic has not been extended to matters relating to health and welfare.[18] Little work on petitions has been undertaken in Germany, either in the field of medicine, or for the sixteenth-, seventeenth- or early eighteenth-centuries.[19] Obviously, this omission is partly explicable by source survival rates. Nevertheless, even when these types of documents have been utilised, they have rarely been given a central role, but have instead been used as incidental evidence to illustrate a wider historical argument regarding the history of hospitals or poor laws. With the exception of the aforementioned work of Christina Vanja and H. C. Erik Midelfort – which will be discussed in greater detail in due course – previous studies of Haina and Merxhausen have largely failed to mention either the surviving petitions or their content.[20] This, in spite of the fact that literally thousands of these petitions

[17] Obviously this is not to say that this work is exclusively based on England. See, for example, the aforementioned study by Gianna Pomata. (Pomata, Contracting). See also, Davis, Natalie Zemon, Fiction in the Archives: Pardon Tales and their Tellers in Sixteenth-Century France, Stanford, California, 1987.

[18] Concerning aspects of 'village communication', see Schlögl, Rudolf, 'Bedingungen dörflicher Kommunikation. Gemeinde Öffentlichkeit und Visitation im 16 Jahrhundert', in Rösener, Werner (hrsg.), Kommunikation in der ländlichen Gesellschaft vom Mittelalter bis zur Moderne, Göttingen, 2000, pp. 241 – 262. Also of particular interest in the same collection of essays is Lorenzen-Schmidt, Klaus-J., 'Schriftliche Elemente in der dörflichen Kommunikation in Spätmittelalter und Früher Neuzeit: das Beispiel Schleswig-Holstein', pp. 169 – 188.

[19] For the later period/ for exceptions to this rule, see, for example, Blum, Peter, Staatliche Armenfürsorge im Herzogtum Nassau, 1806 – 1866, Wiesbaden, 1987; Demandt, Karl, Die Siegener und Dillenburger Regierungsprotokolle Graf Johanns VI von Nassau 1561 bis 1562, Historische Kommission für Nassau, Wiesbaden, 1986; Grosse, S. et al, 'Denn das Schreiben gehört nicht zu meiner täglichen Beschäftigung'. Der Alltag kleiner Leute in Bittschriften, Briefen und Berichten aus dem 19. Jahrhundert. Ein Lesebuch, Bonn, 1989. For a 'literary critique' of eighteenth- and nineteenth-century pauper letters see Sokoll, Thomas, 'Selbstverständliche Armut. Armenbriefe in England 1750 – 1834', in Schulze, Winfried (hrsg), Ego-Dokumente. Annäherung an den Menschen in der Geschichte, Berlin, 1996, pp. 227 – 274. I would like to thank Thomas Sokoll for kindly providing me with a copy of this article. For an alternative view of 'letter writing' in a later period, see Loetz, Francisca, 'Leserbriefe als Medium ärztlicher Aufklärungsbemühungen: Johann August Unzers "Der Arzt. Eine medizinische Wochenschrift" als Beispiel', Jahrbuch des Instituts für Geschichte der Medizin der Robert Bosch Stiftung, Band 7, Stuttgart, 1988, pp. 189 – 204.

[2] Further exceptions to this include references found in the exhibition catalogue for Haina, Boucsein, Heinrich et al (hrsg.) 800 Jahre Haina. Kloster – Hospital – Forst. Eine Ausstellung des Landeswohlfahrtsverbandes Hessen in Zusammenarbeit des Ev. Kirchengemeinde Haina, Landeswohlfahrtsverbandes Hessen, Referat Öffentlichkeitsarbeit, Kassel, 1986. (Unsurprisingly, other than basic contextual information, no other analyses of the text are present here.) Also, Stöhr, Ulrich, '"Armer, lahmer, gebrechlicher Mensch". Segenreiche Unterstützung durch das Kloster Haina', in Frankenberger Heimatkalender, 16. Jahrgang, 1998, pp. 91 – 96. I would like to thank Herr Stöhr for providing me with a copy of this article.

survive. It is perhaps an unsurprising omission when one considers the 'agendas' of the authors of many of the earlier works who were frequently either practising as doctors in the hospitals or who were involved in some way in their administration.[21] Until now these *Reskripte* have not been specifically used as a way for the historian to understand the self-experience of the poor in the early modern period. In contrast, this angle will form a major part of this thesis.

The use of pauper petitions within historical enquiry is not without its critics. As Lindemann has commented, 'the underlying methodological problem' in utilising such written sources is the question of 'how ... we move from stories of individuals acting to a crafting of larger analyses of society and mentality'.[22] What can we really glean from such documents? Unsurprisingly, most criticisms have centred on issues of validity and the 'authentic voice'. Common questions have also dealt with the categorisation of the material - where do we place these sources within historical enquiry? If, as is the case with most of the petitions that we are concerned with here, at least one of the letters that would constitute a formal petition is written by someone other than the applicant themselves, we are left with the question of how to utilise this source. Are we still to consider it to be the voice of the poor, as narrated to a scribe or a literate friend or neighbour, or are we to dismiss it as a quasi-elite voice, which has replaced the words of the applicant with its own language? Within the transmission of information between narrator and scribe, do we consider that sufficient changes have occurred to the original manuscript to render such a document invalid as evidence of the 'voice of the poor'? Indeed, how do we define 'the poor'? Does an offer to pay their remaining wealth – including clothing and bedding – to the hospital negate their status as the 'poor'?

An equally common concern when dealing with this form of documentation is found within the issue of the truth and validity of the statements made within the petitions themselves. How far does the necessity to conform to the entrance

[21] Perhaps the best examples of this type of study can be found in the articles written by Carl Wickel – see bibliography – and Holthausen, Landeshospital. Holthausen was the senior doctor at Haina. For a brief discussion of this style of historiography see Lindemann, 'Introduction' in Idem, Medicine.

criteria of the institutions to which one is applying render the application itself merely formulaic? To what extent does this make void the statements made within the documents themselves? Can one argue that, instead of hearing the true voice of the poor, we are in fact witnessing the imposition of 'elite notions' (by which I am referring to the criteria set by those in charge of such institutions) to the labouring classes? Should we categorise these petitions are being exemplary of the beginnings of the rise of an absolutist state over its subjects? In short, how are we to deal with the content of these documents, and usefully employ it as a subject of historical enquiry? This thesis advocates that through a careful reading of the sources we are able to come as close to aspects of 'the voice of the poor' as a historical perspective of the early modern period is ever likely to allow us. Regarding the importance and 'the unique quality of pauper letters', Thomas Sokoll has stated: 'they provide a rare direct personal record of what the poorest people of society felt and thought, including such intimate matters as the suffering from illness and the experience of old age'.[23] The alternative – dismissing these texts through over-excessive caution – would be to lose a valuable source that offers us insights into the experiences of the poor. It would involve returning to the sources upon which most studies regarding 'patient history' rely all too heavily – predominantly the 'ample documentary remains ... [of] the urban middle classes', and the surviving accounts of physicians.[24] In spite of their undoubted flaws and agendas, the Hessian petitions, if utilised with caution, are indispensable in offering us a broader view regarding illness and care in the early modern period.

One should never lose sight of the fact that these *Reskripte* will always be 'official' pieces of correspondence, written for a specific purpose and with the intention of conveying a clear message which, it was hoped, would result in a premeditated outcome – admission into the hospital. In this sense, these documents are highly strategic pieces of writing. It is the contention of this study that, in spite of these drawbacks, the information within these sources can, for

[22] Lindemann, Mary, Health and Healing in Eighteenth-Century Germany, Baltimore & London, 1996, pp. 6 – 7.
[23] Sokoll, Thomas, 'Old Age in Poverty: The Records of Essex Pauper Letters, 1780 – 1834', in Hitchcock et al, Chronicling, pp. 127 – 154, here p. 127.

the most part, be regarded as the 'truth'.[25] It is important to deal with this aspect of 'truth' as it will be understood in this thesis. Obviously the legitimacy of some of the claims made by individuals regarding emotions and relationships elude us. We cannot, for example, categorically verify the sentiments evoked in the long-term care of a relative. Nor can we make definite assertions regarding an individual's subjectivity. Such issues are impossible to prove and where glimpses can be found in the texts consulted here, they relate at most to the individual's perceptions at one given moment. This does not negate the merit of uncovering and discussing such self-perceptions however – provided that one does not try to make claims that the documents cannot substantiate. The 'truth' which is present here relates to the petitions themselves. The language used and the examples cited by applicants as evidence of worthiness for hospital admission can, if handled carefully, offer valuable insights into the perceptions of the sick regarding their ailments.[26] Such sources can serve to 'deepen our understanding of how people envisioned their social, political, economic and cultural milieu: they reveal to us how people in the past saw their positions in their world; how they related to others, to government, to disease, to their own physicality, and to their environment'.[27] Throughout the petitions there is evidence of individuals' 'subjective understanding of their lives and times infiltrat[ing] their objective arguments' about admission to hospital.[28]

With reference to the question of validity vis-à-vis the claims made within these reports, one crucial point must be taken into consideration. The authorities were as aware as the historian of the problems of assessing the truths of the claims.[29] As a result, all testimonies had to be corroborated by many other witnesses -

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[24] Quote taken from Porter & Porter, Patient's, p. vi. Examples of this work include most notably MacDonald, Mystical; Duden, Woman.

[25] See also the comments in Sokoll, 'Old', pp. 130 – 135.

[26] See also the discussion in Lindemann, Health, p. 7. Compare to Blum, Staatliche, pp. 6 – 7.

[27] Lindemann, Health, p. 7.

[28] Troyansky, David G., 'Balancing social and cultural approaches to the history of old age and ageing in Europe. A review and an example from post-Revolutionary France', in Johnson, Paul & Thane, Pat (ed.), Old Age from Antiquity to Post-Modernity, London, 1998, pp. 96 – 109, here p. 105. Compare to the comments made by Merry Wiesner in her article, 'Making Ends Meet: The Working Poor in Early Modern Europe', in Sessions, K. C. & Bebb, P. N. (eds.), Pietas and Societas. New Trends in Reformation Society. Historical Essays in Memory of Harold J. Grimm, USA, 1985, pp. 79 – 88, here pp. 85 – 86.

including at least local officials, pastors and, from the eighteenth-century, a doctor. Such rigorous checking would, to my mind have made lying futile. Moreover, as Sarah Lloyd has pointed out in her study of the Magdalen Hospital in eighteenth-century London, it was in the hospitals' own interest to ensure that they were able to detect – or, to my mind more importantly, that other people believed them to be capable of detecting – fraudulent claims.[30] This was perhaps even more important within the institutions under consideration here. After all, the founder of the *Landesspitäler* was also the Landgrave, the ruler of the state of Hesse. An inability to distinguish the validity of applications would not reflect well on the Landgrave's political power and judgement. Perhaps more importantly – as will be discussed in greater detail in Chapter One – the hospitals were established within secularised former monastic institutions during the Hessian Reformation. This move was not uncontested, and the Landgrave's power over these institutions rested largely upon his ability to put the institutions to a 'more Christian' use than the former tenants, the monks and nuns, had.[31] Ensuring that only the 'worthy' entered these hospitals was therefore a crucial prerequisite for the process.

It is the contention of this thesis that the reports must largely be taken as written, for it is through this procedure that we will come closest to understanding the early modern perception of the situation. As Barbara Duden has observed, perceptions of physicality are historically (and, I would argue, individually) determined, and it is difficult for us to transcend out own "medicalised" perceptions and to adopt our ancestors' mindsets.[32] This thesis will nevertheless attempt to take such issues into consideration, and the accounts of affliction as evinced in the petitions will be accepted as 'true', in a historically relativist

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[29] Such comments have been made by Troyansky in his study of the system of applications for retirement pensions and widows' and orphans' assistance sent to the Justice Ministry in post-revolutionary France. Troyansky, 'Balancing', p. 106.

[30] Lloyd, Sarah, ''Pleasure's Golden Bait'. Prostitution, Poverty and the Magdalen Hospital in Eighteenth-Century London', History Workshop Journal, Issue 41, Spring 1996, pp. 51 – 72, here p. 62.

[31] Unfortunately lack of space means that, although these issues will be alluded to in Chapter One, they will not be tackled in great detail. For more information see especially Franz, Eckhart G., 'Landgraf und Kloster. Die Zisterzienser-Abtei Haina vor und während der Reformation', in Heinemeyer, Walter & Pünder, Tilman (hrsg.), 450 Jahre Psychiatrie in Hessen, Veröffentlichungen der Historischen Kommission für Hessen (henceforth VHKH) 47, Marburg, 1983, pp. 21 – 34; Midelfort, 'Protestant', p. 78.

sense. (Retro-diagnosis will not form a part of this study, as we are concerned with the early modern perception of the body.)

To avoid a biased reading of the situation, it must be noted that few documents survive in which the patient was denied access.[33] We only know which cases were deemed 'worthy'. Some sources exist, however, in which the petitioner has had to re-submit their application because not all of the criteria were fulfilled. (Usually this meant that an insufficient number of corroboratory reports had accompanied the application.) We also hear little more about the experiences of the majority of patients after they enter the hospital. Care has to be taken in the instances when documents to the contrary do exist, for we do not know if the circumstances detailed in these sources are exceptional, or if the text in question has survived while others have not. Evidence of more than one application relating to an individual does however exist, which allows us to chart the progression of many aspects related to a chronic illness. (These include self-perception, the ability to cope, and family care.) This document base stems out of the fact that overcrowding quickly became a perennial problem for the hospital authorities. Individuals who were theoretically granted entrance to the hospital could find themselves waiting for a considerable period of time before being admitted. In 1706, for example, a certain Johann Georg Reüther re-applied for his blind son to be taken into Haina. Although the latter's earlier request had been granted on 20th March, 1702, he was still waiting for the promise to be realised.[34] Such sources bring home to us the reality of the situation for many of the applicants - although, as aforementioned, the overcrowding cases usually only relate to successful pleas - and frequently give additional detail regarding the experiences of the petitioner in the interim.

In spite of all of the concerns highlighted above, the hospital archives upon which this thesis is based form an immensely rich source. On the basis of this I aim to gain some insight into the self-perception of the sick labouring poor with

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[32] Duden, Woman, pp. 1 – 49.
[33] Fissell, Mary E., 'The Sick & Drooping Poor in Eighteenth Century Bristol and its Region', Social History of Medicine, Volume 2, Nr 1, April 1989, pp. 35 – 58, here p. 44.
[34] Archiv des Landeswohlfahrtsverbandes Hessen (henceforth LWV), Bestand 13, Reskripte, April 1706.

regard to their physical infirmities and their capabilities. These are, after all, a group whose voices are usually silent in surviving historical documentation.

II. The current state of research regarding Haina and Merxhausen.

The few studies of Haina and Merxhausen that exist to date largely chart the history of these territorial hospitals from an institutional, administrative and bureaucratic perspective.[35] Within the early modern period, the focus has predominantly been either upon the various ordinances that survive or, to a lesser extent, upon the people who worked within these hospitals. Regarding the latter, interest has usually navigated towards the regulations established by the Landgrave or superintendent of the institutions regarding the duties of hospital employees, or upon key figures regarding whom much documentation is extant.[36] The patients themselves have seldom been referred to. With the exception of the interest accorded to the mental patients of the hospital, as is seen in the work of Christina Vanja and H. C. Erik Midelfort, the pauper petitions themselves have remained largely untouched by historical study. In the majority of instances, the main interest in the studies of these two authors relates to the wider history of madness. They are thus primarily concerned with this section of the inmate population.[37] All too often in historical study, 'interesting' conditions, such as madness, capture our imaginations and become the focus of investigation. Works remain largely silent about the more common ailments that would have effected, in varying degrees, a wider cross-section of the population. As fascinating as such examinations of madness may be they serve, when considered in isolation, to ultimately skew our perception of early modern society. In the case of Haina and Merxhausen, as will be shown, a large proportion (during some periods the majority) of patients were suffering, not from mental illnesses, but from a variety

[35] Perhaps the clearest example of this trend can be found in the most comprehensive work relating to Haina and Merxhausen to date, Heinemeyer & Pünder (ed.), 450 Jahre.

[36] This is particularly true of Heinz von Lüder. Examples of this bias of interest can be seen in Holthausen, Paul, Das Landeshospital Haina in Hessen – eine Stiftung Landgraf Philipps des Großmütigen von 1527 – 1907, Frankenberg, 1907. Regarding the *Obervorsteher* von Stamford, see Kahm, Otto, Freidrich vom Stamford. Obervorsteher der hessischen Samt-Hospitäler, Frankenberger Hefte, Nr. 5, 1997.

[37] One exception to this rule is Midelfort, 'Protestant'. By the same token, perhaps the clearest indication of this leaning is Midelfort, Madness, pp. 322 – 384.

of forms of physical illnesses. Thus to focus solely upon the mental patients within the institution is to offer a biased picture of the role of these hospitals within the territories, from the perspective of both the founder and the Hessian population. It is the intention of this thesis to rectify this omission by concentrating upon those patients suffering from chronic physical ailments. Essentially this involves all of the cases that did not constitute mental illness although, as will be seen, with some conditions – most notably epilepsy - the physical and the mental frequently become entwined.

This thesis will examine the establishment of these hospitals at the onset of the Reformation and will investigate the motivations of the territorial prince of this region in founding such institutions, and the place that they were believed to hold within the wider social and political framework of the territory as a whole. Documentation such as the foundation ordinances will be contrasted to the pauper petitions to gain a wider and more nuanced view of the place of these hospitals within society. Chapters on family care, old age, and work will evaluate the poor's experience of illness prior to hospitalisation. An overarching theme of this study focuses upon the misconception of the poor as passive recipients of relief. Issues such as the way in which the poor coped with their physical infirmities prior to hospitalisation will play a large role in this investigation. The perceptions of the inmates regarding the place of these institutions within their 'illness experience' and life-cycle strategy will be compared to the motivations both of the founder and of those in charge of the day-to-day running of the establishments.

Much work still needs to be done regarding the histories of both Haina and Merxhausen. To date most research has been done concerning the former institution, with the latter receiving relatively scant attention.[38] The reason for this is not exactly clear, but may be partly due to the fact that Haina was often regarded as being the administrative centre of the state hospitals, as will be

[38] For a brief history of Merxhausen, see, among others Brunner, Hugo, 'Kloster Merxhausen' in Jahrbuch der Denkmals Pflege in Regierungsbezirk Kassel, Band 1, Marburg, 1920, especially pp. 118 – 125.

detailed in due course. Moreover, for some aspects of the hospitals' history, the survival rate of documentation is better for Haina than for Merxhausen.

It is not the intention of this thesis to provide an institutional history of Haina and Merxhausen in the traditional sense of the term. While there is much that remains to be written regarding these institutions, it would detract from the intentions of this enquiry to become too deeply engrossed with their daily minutiae and bureaucracy. Chapters One and Two will concentrate upon an overview of the hospital history. The first chapter will focus upon the main issues connected to the establishment and the running of these institutions that it is necessary for the reader to know in order to shed light on the possible motivations for an application. To this end, this section will consider themes such as the foundation of the hospital at the onset of the Hessian Reformation, the daily running of these hospitals as evidenced in the ordinances, and the major administrative and bureaucratic changes which took place during the period in question. A discussion of the impact of a variety of internal and external events upon these hospitals will also feature here. Chapter Two will give attention to life within the institutions, shedding light upon such issues as the layout of the hospitals and the daily routine of the inmates. The focus will then shift to consider the patients themselves. Chapter Three will look at the medical treatment that one could expect to receive in Haina and Merxhausen. The latter topic is of particular importance as it is a matter that has hitherto either been wholly ignored or been glossed over in studies of these institutions.

Having alluded to the dangers of merely equating the contents of the foundation ordinances with the reality of the hospital life, the subsequent three chapters will compare the understanding of the founder concerning the point at which a prospective patient would wish to be hospitalised to the perceptions of the applicants themselves. Three of the central preconditions of admission were that an applicant would be deemed worthy of assistance if they were old, without the support of friends or family, and were wholly unable to support themselves through work. ('Old' referred to persons over 60 years of age – younger applicants suffering from chronic conditions were also eligible to apply.) Obviously, such stipulations regarding the 'worthy poor' were familiar constants

throughout much of Europe during this period, and these categories are frequently recited within studies on the poor at this time.[39] The lack of research and/or available documentation has however meant that studies of the sixteenth- to early eighteenth-century have rarely given much additional information regarding these points.[40] Through careful analysis of the Hessian pauper petitions, this enquiry aims to assess the importance which old age, chronic illness, lack of additional support (both kin and non-kin), and the inability to work held for potential applicants. The aim is to reveal that the petitioners themselves understood these terms in a much subtler and more subjective manner. In spite of the individualised nature of this source, common threads are abundantly clear throughout the multitude of petitions. One of the main objectives of this enquiry is, therefore, to offer a more nuanced interpretation of the reasons in which these petitioners applied to the hospitals in question. These findings will then be compared to information within both historical studies to date and also within the ordinances themselves. Rather than the poor appearing as statistical lists of names, or as a category for poor relief and charitable assistance, this thesis will endeavour to explore the reality of the experience of poverty and chronic illness within the localised setting of Hesse, as it relates to those patients who applied for admission to the territorial hospitals of Haina and Merxhausen.

Chapters Five and Six will question the way in which the use of sources can influence historical observation, and will concentrate upon the central themes of self-perception. Sections of each of these chapters will focus upon a broader view of the hospital, and upon slightly different sources, within which the patient (both potential and actual) still played a central role. Documents relating to complaints from both patients and staff, regarding issues of appropriate behaviour will be considered to offer a wider view of the role that these hospitals were deemed to play within the lives of the afflicted. In addition, petitions will also be consulted in which the applicants sought poor relief in the form of food,

[39] For discussions regarding the 'worthy poor', see Parker, Charles H., The Reformation of Community. Social Welfare and Calvinist Charity in Holland, 1572 – 1620, Cambridge, 1998, pp. 123 – 146.

firewood or clothing, rather than asking for hospitalisation itself. These sources will be compared to those of the applicants requesting admission in an effort to understand in what way the former individuals' perception of their illness and their capacity to cope differed from the latter to ensure that they felt able to manage life outside the confines of an institution.

In a sense, therefore, this thesis can be summarised as a form of *Alltagsgeschichte* relating to chronic illness, poverty and institutions within the context of a specific and localised setting. It is hoped, however, that this enquiry will go further than that. One of the epitaphs that featured in each of the four territorial hospitals states that 'this is a hospital for the poor' *('Dies ist ein Armen Hospital')*. The primary focus of this thesis is to ascertain what this really meant to the individuals involved. At which point in one's life, and for what reasons, did one feel ready to apply to enter an '*Armen Hospital*' in which they could reasonably expect to spend the rest of their lives? This enquiry aims to move away from the tendency to view both the 'poor' as a mass category, and the 'sick poor' as one of a list of medical conditions, and to restore to them a voice which will offer more detail regarding the reality of both of these states of being. As Imhof comments in the introduction to his book '*Die verlorenen Welten*', 'I have ... attempted ... to look at the world of our forefathers through their own eyes. ... I wanted to know what they thought their own problems were, what those problems looked like, and how they came to terms with them. ... I therefore stepped back from the computer and all of the magnetic tapes and looked individually at these ancestors of ours before they disappeared by the thousands into the computer, only to appear anonymously again at the end as statistical averages.'[41] This will form one of the main preoccupations of this thesis – particularly within Chapters Three to Six which focus more closely upon the pauper petitions themselves. While mindful of both the necessity of a careful reading of the source material and also of the dangers of making generalised

[40] Exceptions to this can be found in the collection of essays by Margaret Pelling in Idem, The Common Lot. Sickness, Medical Occupations and the Urban Poor in Early Modern England, London & New York, 1998, especially pp. 63 – 104, 134 - 154.

[41] Imhof, Arthur E., Die verlorenen Welten. Alltagsbewältigung durch unsere Vorfahren – und weshalb wir uns heute so schwer damit tun, München, 1984. Translated by Thomas Robisheaux: Lost Worlds. How Our European Ancestors Coped with Everyday Life and Why Life is So Hard Today, Charlottesville & London, 1996, pp. 2 – 3.

assertions from texts which deal with individuals, it is hoped that this thesis will offer some insight into the experiences of the sick poor considered here. Too much emphasis to date has been afforded to administrative histories of hospitals that serve to categorise the institutions within an historical framework. Too often, the sick poor only appear as numbers on a statistical table. This thesis hopes to go some way to redress this balance, by concentrating upon their 'voices'.

CHAPTER 1
THE FOUNDATION OF THE TERRITORIAL HOSPITALS

'We Philip [sic] by the Grace of God Landgrave of Hesse, Count [*Graff*] of Catzenelnbogen, Dietz, Ziegenhain und Nidda, ... our heirs and future princes of Hesse and counts of Ziegenhain, ...as the territorial prince and sovereign have ... given the people [i.e. the monks] their leave [*Abfertigung*] as was their desire, ... and ... have ordered ... that henceforth [and] for all eternity the ... monastery should be a hospital for the poor and the rents, goods and privileges will remain with all of the rights ... that are currently in use ... and [the hospital] will be maintained thereby...'[1]

So read the 1533 foundation letter (*Stiftungsbrief*) for Haina. From 1533 onwards, Haina (as indeed Merxhausen, for which a similar letter exists) was to be a 'Hospital for the Poor'. But what did this mean in practice? This chapter will offer a broad overview of the institutional history of the hospitals of Haina and Merxhausen from their conception to the early eighteenth-century.

Most historical study to date has focused predominantly on Haina, and has either concentrated upon the early part of the institution's history – most frequently, charting the secularisation and the first ordinance of 1535 – or leapt to the eighteenth century and beyond. Where Merxhausen has been the subject of historical investigation, it has suffered the same fate.[2] A certain amount of

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[1] LWV, Bestand 13, Hospitals-Ordnungen und Vergleiche (Haina), catalogued within the Instructions- und Verordnungsbücher 1659 – 1744 – 1770. From the Stiftungsbrief vom 26/08/1533. The full German extract reads as follows: *'Wir Philips von Gottes Gnaden, Landgraff zu Hessen, Graff zu Catzenelnbogen, Dietz, Ziegenhain und Nidda, bekommen hier in unsern [Stiftungs]brief, vor Unß, Unsere Erben und Nachkommende Fürsten zu Heßen und Graffen zu Ziegenhain, offentlichen gegen männiglichen nach dem die Ordens Persohnen so zu Haina im Closter gewesen, durch Vererhung Gottes Gnaden zu seines Wortes bekendtnüß kommen, und sich demnach auß dem Closter in weltlichen standt begeben, so haben wir alß der Landts Fürst und Oberherr unß derselbigen Closters unternommen, den Persohn auf Ihr begehren Ihre Abfertigung geben, folgenß Gott dem Allmächtigen zu Lob, Her und Preiß daßelbige Closter mit einer guten Notthurft Zinß und Gefällen und Guthern wie die verzeichnet seÿndt, Inhalt der jetzigen vorstender berechnetem Register zu einem Spittal und Unterhaltung armer Leüthe verordnet haben ... daß nun hinfurt zu ewigen Zeiten das ermeltes Closter ein Spital der Armen und die Zinß Güther und Gefälle mit aller Gerechtigkeit wie die Armen die jetzt im Gebrauch haben, darbeÿ bleiben und es damit gehalten werden soll... '*

[2] Perhaps the best illustrative examples of this include Schenk, Heinrich, Geschichte des Hospitals Haina und Merxhausen nebst einem Lebensbild des Begründers, Frankenberg, 1904, esp. pp. 14 – 16; Brunner, Hugo, Jahrbuch des Denkmals Pflege in Regierungs Bezirk Kassel für

repetition of the basic chronological facts as detailed in previous works is unavoidable if this section of the inquiry is to provide the background necessary to enable a careful understanding of the pauper petitions. Nevertheless this chapter will also focus upon issues that have received, at best, limited attention. It will focus upon an assessment of the context of the foundation of these hospitals, and an analysis of the hospital ordinances. Events and issues that were potentially problematic for these institutions – such as overcrowding and war - will then be considered with a view to evaluating their impact upon the admissions procedures and to offer us a broader picture of these two establishments than has hitherto been undertaken.

I. Reformation and secularisation. The foundation of the Landesspitäler.

Both Haina and Merxhausen were established as a direct result of the Reformation policies of the Protestant Landgrave of Hesse, Philip the Magnanimous, on the eve of the Reformation in Hesse.[3] Formally a wealthy

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die Zeit vom 1/1/1914 bis 1/1/1917, Marburg, c.1917, pp. 69–73, 118–125; Haupt, P., 'Einiges vom früheren Kloster und den jetzigen Landesheilanstalt Merxhausen. Zur Information des Beirates des Kommunalverwaltung im Regierungsbezirk Kassel zu seiner Tagung am 29 Juli 1946 in Merxhausen', 1946, unpublished; Anon, 'Unser täglich Brot gib uns heute...', Der Klosterbote, Merxhausen, Oktober 1958, II Jahrgang, Nr. 3. Mit dem Bericht über die 425-Jahrfeier des Krankenhauses am 26 August 1958; Anon, Niedensteiner Heimatbuch Hess., 1954, pp. 33 – 34; Jacob, Bruno, 'Kloster Haina. Ein kurzer Gang durch seiner Geschichte', in Meine Heimat. Eine Jahrbuch geschichtlicher Nachrichten und bedeutender Ereignisse im Kreise Frankenberg, 3. Jahrgang, 1935, Frankenberg – Eder.

[3] A discussion regarding Philipp's attempts to reform the monasteries prior to the Reformation, coupled with a study of the secularisation of the hospitals and the resistance that Landgrave Philipp encountered (especially from some of the former monks of Haina) cannot unfortunately fit within the confines of this thesis. Regarding the Hessian Reformation, see Heinemeyer, Walter, Philipp der Großmütige und die Reformation in Hessen. Gesammelte Aufsätze zur hessischen Reformationsgeschichte, VHKH, 24,7, Marburg, 1997. For an excellent summary of events surrounding the secularisation process, see Heinemeyer, Walter, 'Armen- und Krankenfürsorge in der hessischen Reformation', in Heinemeyer & Pünder (hrsg.), 450 Jahre, pp. 1 – 20; Franz, 'Landgraf', pp. 21 – 34; Schilling, Johannes, 'Die Bedeutung von Klöstern und Mönchen für die Reformation in Hessen. Zur Vorgeschichte des evangelischen Pfarrstandes', Zeitschrift des Vereins für hessische Geschichte und Landeskunde, Band 102, 1997, pp. 15 – 24; Jaspert, Bernd, 'Reformation und Mönchtum in Hessen', Jahrbuch der hessischen Kirchengeschichtlichen Vereinigung, Band 28, 1997, pp. 56 – 81. Regarding the earliest history of the hospitals, see, among others, Sohm, W., Territorium und Reformation in der hessische Geschichte, 1526 – 1555, VHKH, Band 11, Marburg, 1957; Franz, Eckhart G. (hrsg), Kloster Haina. Regesten und Urkunden. 2. Band (1300 – 1560), VHKH und Waldeck, Band 9, Marburg, 1970; Demandt, Karl, 'Die Hohen Hospitäler Hessens. Anfänge und Aufbau der Landesfürsorge für die Geistesgestörten und Körperbehinderten Hessens (1528 – 1591)' in Heinemeyer & Pünder (hrsg.), 450 Jahre, pp. 35 - 134, especially pp. 37 – 42; Friedrich, Otto, Merxhausen. Seine Geschichte als Kloster und Landeshospital, Marburg, 1932, pp. 9, 29; Franz, Gunther,

Cistercian monastery, Haina was dissolved in 1527 following both the Diet of Speyer in 1526 (which granted German territories the responsibility for the religion practised in areas under their rule), and the Homberg Synod. Although never put into legal effect, the Synod's decisions revealed an interest in redirecting monastic property to 'common use'. To an extent, the *Landesspitäler* are an example of a rural society following the pattern that had been witnessed in German towns in this period, whereby initiatives to organise poor relief passed (almost completely, irrespective of confessional alliance) from ecclesiastical into lay hands.[4] In Haina and Merxhausen, however, one has the interesting paradox of the establishments moving into the hands of the secular ruler of the state, who was both spear-heading a campaign of ecclesiastical reform in Hesse (namely the Protestant Reformation), and using these institutions to promote the 'new religion' within his territories.

Haina and Merxhausen were officially established as hospitals in 1533. They became two of the four *Landeshospitäler* (state hospitals) that were established by the Landgrave in this period to look after the sick poor in the Hessian countryside. Haina, in Upper Hesse, was to deal specifically with male patients, as was Gronau, which was in the Lower Hessian district of Catzenelnbogen and which had previously been a Benedictine monastery. Hospitals reserved for female patients were founded at the former Augustine monastery of Merxhausen in the Lower Hessian district of Kassel, and at the dissolved provostship of Hofheim in Upper Catzenelnbogen, near Darmstadt.[5] The latter was established as a hospital in 1534. Unfortunately, a detailed analysis of the political and geographical history of Hesse, summarised succinctly by Karl Demandt's

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Urkundliche Quellen zur hessischen Reformationsgeschichte. Band 2: 1525 – 1547, Marburg, 1954; Dersch, W., Hessisches Klosterbuch, VHKH XII, Marburg, 1940, p. 90; Demandt, Karl, 'Die Anfänge der staatlichen Armen- und Elendenfürsorge in Hessen', Hessisches Jahrbuch für Landesgeschichte, 30, 1980, pp. 176 – 235, here pp. 179 – 182, 186 – 187 ; Arnoldi, J., 'Kurze Geschichte des Klosters Haina', in Justi, K. W., Hessische Denkwürdigkeiten, Marburg, 1799, especially p. vii; Midelfort, 'Protestant'. For a general context regarding the Reformation, see Heinemeyer, Walter, 'Das Zeitalter der Reformation', in Heinemeyer, Walter (hrsg.), Das Werden Hessens, Marburg, 1986, pp. 225 – 267.

[4] Jutte, Robert, 'Poverty and Poor Relief', in Ogilvie, Sheilagh (ed.), Germany. A New Social and Economic History. Volume II. 1630 - 1800, London & New York, 1996, pp. 377 – 404, here p. 396.

[5] For a brief summary regarding the foundation of Gronau and Hofheim, see Demandt, 'Anfänge', pp. 188 – 196.

Geschichte des Landes Hessen, is outside the confines of this thesis.[6] Essentially, however, the geographical distribution of these hospitals was such that one hospital was roughly placed in each quarter of Hesse, thus spreading this potential care network relatively evenly throughout the territory. Erik Midelfort asserts that the way in which these institutions were distributed throughout Hesse would mean that the hospitals could be supported 'more easily through local resources'.[7] Gronau, founded in 1542, was destroyed in the Thirty Years War (1618 – 1648), after which time all of its income went to Haina. The property was sold in 1824, and the proceeds from this sale were evenly split between the three remaining hospitals. It appears that Hofheim was also taking in male patients by the end of the sixteenth-century. To a large extent, however, Merxhausen and Haina retained the original gender distribution of their patients. This thesis will focus upon the latter two hospitals.

The concept behind the *Landeshospitäler* was that the sick poor from the surrounding countryside would find free shelter and care within these institutions. The first hospital order (*Ordnung*) of 1535 clearly stated that these establishments were deemed for the poor from the villages, and not the towns, of the principality (*Fürstenthum*).[8] As such, the hospitals were allowed to retain a certain proportion of their monastic wealth and would be run from the proceeds of this revenue. In theory, therefore, they would be self-financing. A recent estimate suggests that Haina was allowed to retain one fifth of its former monastic wealth.[9] Most of the rest of Haina's property and the attached revenue - such as estates [*Höfe*] at Singlis, Treysa, Alsfeld and Fritzlar - helped to finance Marburg University, which had been established in 1527.

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[6] Perhaps the best histories of Hesse during this period include Demandt, Karl, Geschichte des Landes Hessen, Kassel, 1980, 2nd edition; Heinemeyer (hrsg), Werden; Schultz, Uwe (hrsg), Die Geschichte Hessens, Stuttgart, 1983.

[7] Midelfort, Madness, p. 330.

[8] 1534 Hospital Ordnung, in Franz, G., Urkundliche, Nr. 283.

[9] Boucsein et al, 800 Jahre, p. 70. The 1533 foundation letter (*Stiftungsbrief*) ordered that '*diese Closter Haÿna, mit allen deßelbigen Closters Freÿheiten, Gerichten, Rechten, ... Verbott, Holtz, Walt, Waßer, Weidte, Renthe, Zinß, Zehende, Jagt, vnd alllen vmb vndt zu griffen, nichts ausgescheiden...* '. LWV, Bestand 13, Hospitals Verordnungen und Vergleiche.

While one fifth may appear to be a small amount, Haina's monastic wealth had been substantial. [10] Prior to the Reformation, Haina had been one of the most affluent monasteries in Hesse.[11] In North Hesse, its wealth was only surpassed by the Imperial abbeys (*Reichsabteien*) of Fulda and Hersfeld. Even with its wealth cut to a fifth, in 1533 the hospital still owned approximately 7347.40 hectares (ha.) of land. 6723.52 hectares of this was taken up by forests, 218.28 constituted meadow, and a further 323.15 were fields, suitable for agriculture. In addition to this, the hospital owned an iron works, and collected numerous tithes from people using its land.[12] In comparison, at this time Merxhausen owned approximately 913.39 hectares – 586.25 constituting forests, 42.52 meadows, and 249.94 fields.[13] Of the four *Landeshospitäler*, Haina was by far the richest.

With the introduction of the Hessian Reformation, 'the state secularized Church properties and acquired seigneurial authority over the peasants on these lands. Seigneurial institutions and incomes, including rents, tithes, dues, and fines imposed by seigneurial courts were therefore incorporated into the institutions of the state.'[14] Although charitable institutions, Haina and Merxhausen were also 'institutions of the state'. As such, they either took over or were allocated some of the seigneurial lands that had formerly belonged to the monasteries. Merxhausen's assets illustrate this point. The hospital held a variety of rents, tithes and dues (*Gefälle, Grundstücke, Renten, Lehnsabgaben, Rod-, Erb-, Grund- und Hauszins*) in the following places: Sand, Riede, Gudensberg,

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[10] Regarding the wealth of the monastery, see especially Letzener, Johann, Historische, kurtze, einfaltige und ordentliche Veschreibung des Closters und Hospitals zu Haina in Hessen gelegen. Auffs newe übersehen und verbessert, Mühlhausen, 1588, chapter 3; Liemke, Otto, Das Kloster Haina im Mittelalter. Ein Beitrag zur Baugeschichte der Cistercienser Deutschlands, Berlin, 1911.

[11] See, among others, Wickel, Carl, 'Aus der Geschichte des Landeshospitals Haina in Hessen', Die Irrenpflege, Nr. 11, 24 Jahrgang, Februar 1921, pp. 195–196. Eckhart G Franz refers to Haina as 'ohne Zweifel das bedeutendste und besitzstärkste der landsässigen Klöster in der Landgrafschaft' in Franz, 'Landgraf', p.22.

[12] For a brief description of this seigneurial system, as experienced in the village of Leimbach in the district of Ziegenhain, see Imhof, Lost, pp. 14 – 15.

[13] Anon, Zusammenstellung der für die Verwaltung des Bezirksverbandes des Regierungsbezirks Cassel geltenden Gesetze, Verordnungen, Reglements und sonstigen Bestimmungen. Amtliche Ausgabe, Zweite Anlage, Cassel, 1913, s. 261. Holthausen, Landeshospital, p. 62 seems to suggest that these figures relate to Haina's property at the time of his writing. A detailed analysis of the Salbuch (which is outside the scope of this present study) would be necessary to work out the correctness of these claims.

[14] Robisheaux, Thomas, 'The Peasantries of Western Germany, 1300 – 1750', in Scott, Tom (ed.), The Peasantries of Europe from the 14th to 18th Centuries, London & New York, 1998, pp 111 – 145, here p. 135.

Balhorn, Niedenstein, Elben, Böddiger, Ober- und Niedervorschütz, Breitenbach, Hoof, Wichdorf, Ermethies, Metze, Züschen, Fritzlar, Wehren, Werkel. Two larger properties (*Güter*) were held in Merxhausen and Offenhausen. Landgrave Philipp swapped the assets that the former monastery had held in Berg and Gelnhausen for seigneurial rights over the village of Dorla. Tithes (*Zehnten*) were also held in Aldenhasungen, Berningshausen, Sand, and Schalgenhausen. In addition, Haina had a large area of forest and held fishing rights along a large stretch of the river Ems (from Sand to Kirchberg). The hospital itself only 'managed and farmed [*bewirtschaftet*] 18 strips of farmland [*Hufen*], 18 fields [*Acker*], of which 14 were arable land, approximately 4 *Hufen* of meadow and 12 fields [and] 11 *Ruthen* of gardens, in which hops were primarily grown'. The remaining land (the vast majority of its holdings) was rented out (*verpacht)* and was taken over by farmers (*Hofleute*).[15]

It is important to note the wide variety of places in which Merxhausen held lands as many of the place names quoted above appear frequently in the petitions. One could thus perhaps regard the hospitals as extending rights of patronage and protection over the inhabitants in areas in which they owned land, in much the same way that a seigneurial lord would have done – although most of the petitioners were too poor to be direct tenants. A more detailed examination of the relevant sources is necessary, however, before further comment can be made regarding these matters.

[15] Friedrich, Merxhausen, pp. 24 – 25. For later examples relating to the Vogtei of Frankenberg and the villages in this area in which Haina held *Güter* see Friedrich, Arnd & Lay, Heinrich, 'Vogtei Frankenberg im Siebenjährigen Krieg. (2) Kein Gras wuchs mehr in böser Zeit', Frankenberger Allgemeine, Nr. 80, 4 April, 1987.

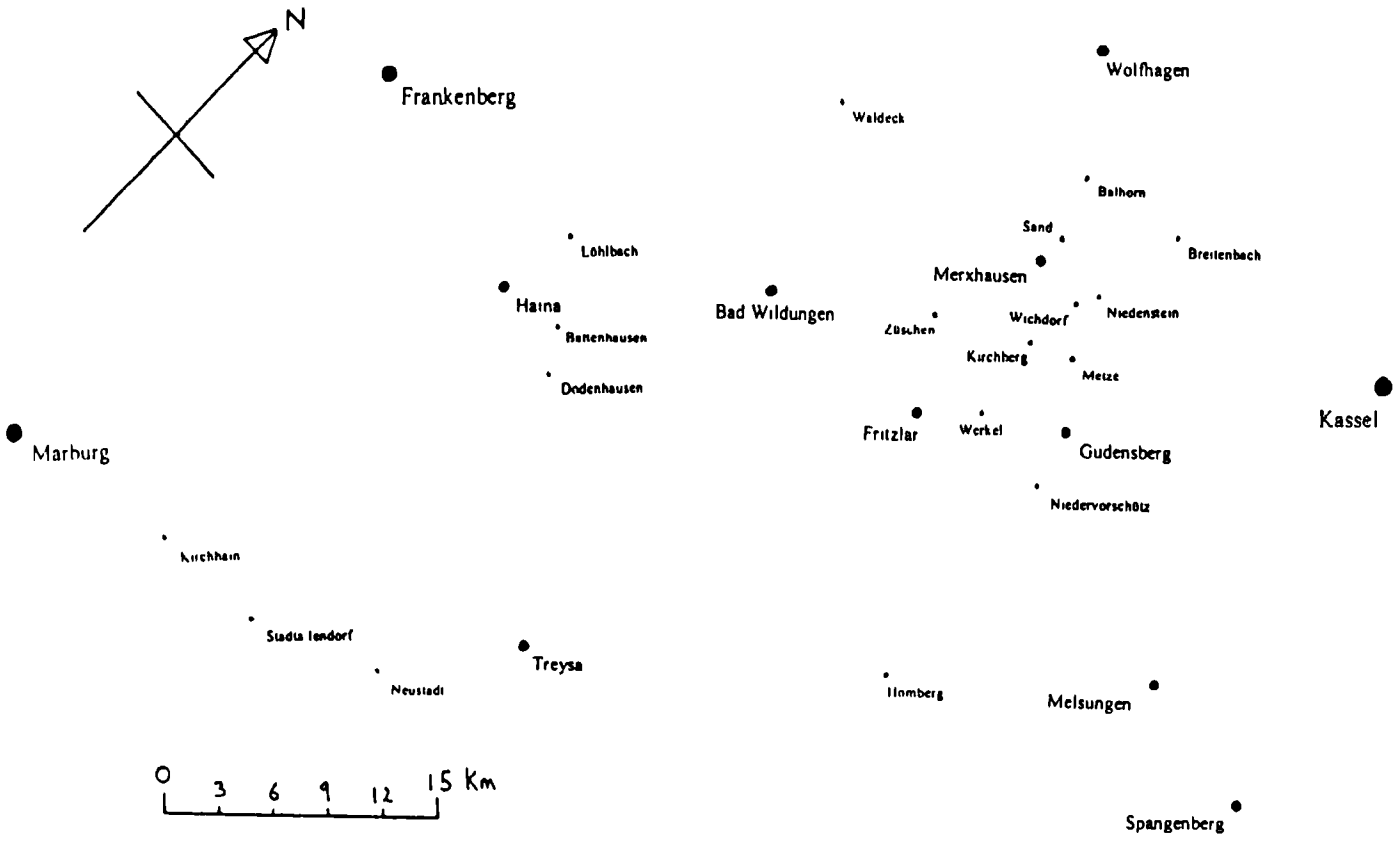

Figure 1: The location of Haina and Merxhausen within Hesse.

II. The *Landesspitäler* and the territorial state.

How are we to explain the foundation of these hospitals - an event which historian Karl Demandt has deemed to be 'such an unusual measure that one really must describe it as a socially revolutionary act of its time'?[16] In order to address this question we must consider Haina and Merxhausen within the wider framework of sixteenth-century Hessian history. We are able to obtain a glimpse into one of the factors which motivated Philip to establish the *Landesspitäler* from his 1533 letter to the Duke of Schleswig-Holstein (later Christian III of Denmark). Written when Haina and Merxhausen were in the midst of their foundation process, Philipp's letter reveals his belief that urban areas were better equipped to deal with poverty and illness, and that many such sites already had hospital facilities.[17] Karl Demandt asserts that 'by the end of the Middle Ages urban hospitals existed in all Hessian towns with the exception of extremely small towns [*Zwergestädten*, literally 'dwarf towns']'.[18] Rural areas, however, had no such provision. Philipp the Magnanimous thus aimed to overcome this bias through the establishment of the four state hospitals.

When one considers that a large proportion of the population in this period lived in rural areas, the importance of his actions can be realised. Sixteenth-century Hesse contained a total of one hundred and thirty-eight towns. Only fifteen of these boasted more than two thousand inhabitants (thus being classed by Holger Gräf as 'medium towns'). These included Kassel, Homberg. Giessen, Alsfeld, Wetzlar and Darmstadt. Gräf states that the largest town was Frankfurt am Main - although, technically speaking, as an Imperial Free City, it was outside the territory of Hesse. It housed almost twenty thousand inhabitants at the end of the sixteenth-century. The vast majority of urban areas in Hesse had small numbers of inhabitants, ranging from five hundred to two thousand persons. Large areas of the territory had predominantly rural patterns of habitation. Few towns (of only marginal significance) existed, for instance, in the hilly regions of the Vogelsberg, Taunus, the Westerwald and Waldeck. A similar situation was

[16] Demandt, 'Hohen', p. 36.
[17] Wright, John William, Capitalism, the State, and the Lutheran Reformation, USA, 1988, p. 191.

present along the eastern fringes of Hesse towards the Thuringian Forest and the Rhön.[19] Indeed, the highland areas of the Vogelsberg and the Wetterau are deemed to have 'had poorer soils and were much more inaccessible to trade and communication'.[20]

In his study of the Werra region of Hesse, John Theibault emphasises that 'Hesse was a land of villages, where agriculture predominated.' This is exemplified by the following brief case study. Only six towns existed in the area neighbouring the Werra river. Of these, the largest was Eschwege – its 1583 population constituted seven hundred and thirty-three households. The other five towns were however, 'barely larger than the largest villages of the region'.[21] The smallest of these, Wanfried, had only one hundred and seventy seven households. Some seventy-eight villages of varying sizes surrounded it. Theibault asserts: 'Some villages were tiny, consisting of no more than ten households; others were as large as a small town, with as many as one hundred and fifty households, but most ranged from about thirty to seventy households in size'.[22] One can only assume that the presence of a chronically (but not terminally) incapacitated person within the smallest of these inhabited areas could have far-reaching implications for the village as a whole. Even in the larger villages, such sickness could also have a similarly adverse effect on the neighbourhood. Evidently the foundation of a facility to care for the rural poor would affect much of the Hessian population. Karl Demandt has commented upon the impact that he believes was quickly made by these 'unprecedented' institutions. He states that the contemporaries' realisation of the hospitals' importance is indicated by the term 'high hospitals' (*Hohe Hospitäler*). A mark of honour and respect, it was used from 1548 onwards to refer to the state hospitals. This does not mean that other names, including 'monastery' (*Closter*)

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[18] Demandt, 'Hohen', p. 36.
[19] Gräf, Holger, 'Small towns in early modern Germany: the case of Hesse, 1500 – 1800', in Clark, Peter (ed.), Small towns in early modern Europe, Cambridge, 1995, pp. 184 – 205, here p. 190.
[2] Robisheaux, 'Peasantries', p. 112. This can be compared to other areas of Hesse, such as the (prosperous) village of Leimbach in the middle of the Schwalm lowlands. In this area the soil was fertile and the climate favourable to agriculture. See Imhof, Lost, pp. 15, 43. It must be noted that some of the villages in this area were so-called '*Adeldörffer*', owned by the nobility. (p.43.)
[21] Theibault, John, German Villages in Crisis. Rural Life in Hesse-Kassel and the Thirty Years' War, 1580 – 1720, New Jersey, 1995, p. 9.
[22] Ibid, p. 9.

were discarded. Various terms were utilised throughout the period under consideration here.

III. The *Landesspitäler* and the Hessian welfare policies.

The foundation of the Landeshospitäler comprised one part of Philip the Magnanimous' scheme to care for the poor and the sick in the Hessian territories. Indeed, Karl Demandt views their establishment as the 'third stage and crowning conclusion' to a social policy of 'unprecedented importance'.[23] Under this programme, approximately fifty religious institutions were secularised, and the proceeds were given to other projects. Demandt has calculated that approximately sixty per cent of the 'conscripted wealth and property of the monastic institutions was utilised for religious, academic and charitable endowments and forty per cent was used for court and state administration costs [*Hof- und Landesverwaltung*]'.[24]

In 1531, prior to the establishment of Haina and Merxhausen, Landgrave Philipp assigned Heinz von Luder and Adam Krafft (both leading figures in the Hessian Reformation) to conduct a statewide visitation of all hospitals and the church chests (*Kirch-casten*) and to assess the situation at each place.[25] From the results of this survey, Landgrave Philipp set out a programme for improving levels of care within Hesse. In small towns such as Gudensberg and Feldsberg, previously existing hospitals were given financial assistance necessary to implement improvements.[26] New hospitals were established in towns which had previously lacked them, as was the case in Marburg, Alsfeld, Schotten, Wolfhagen and St. Goar.[27] Urban institutions were, in theory at least, now reorganised, in an attempt to reverse the previous trend by which many town hospitals had become little

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[23] Demandt, 'Anfänge', p. 185.
[24] Demandt, Geschichte, pp. 226 – 227.
[25] For more information, see Heinemeyer, 'Armen', pp. 17 – 18. Such visitations had occurred since at least 1527. (Ibid, p. 17.)
[26] Also included were Eschwege, Spangenberg, Gemünden an der Wohra, Wetter and Biedenkopf.
[27] Demandt, 'Anfänge', p. 185; Sohm, Territorium, pp. 96 – 97; Anon, Kranken- und Armenpflege in Hessen. Dokumente aus acht Jahrhunderten, Austellung der Hessischen Staatsarchiv zum Hessentag, 1980.

more than retirement centres for rich burghers. Breaking such a tradition was not easy however, as is revealed by the Landgrave's order of 1563, concerning a hospital in the town of Homberg. He stated that 'those rich inmates who had bought their way in and were selfish, not willing to share with the other inmates, and "calling them beggars and reproaching them..., shall be punished or certainly thrown out. ... From now on, one shall let no one in for friendship, favour, or money, but only for deep and naked poverty"'.[28] The hospital ordinances of Haina and Merxhausen reflected similar concerns. The ordinance of 1535, drawn up by the superintendent (*Obervorsteher*) Heinz Lüder, stated that 'such poor people should first and foremost [*vornehmlich*] be accepted every now and again from the villages in the principality and not from the towns. And such poor people, according to God's will, shall only be regarded in terms of poverty and need, and not according to favour [*Gunst*], friendship or gifts [*Gaben und Geschenck*]'. [29] It would appear then that, following Philip's reorganisation of the hospitals, similar admissions criteria were theoretically required to gain entry to both some of the (small) town hospitals and the *Landesspitäler*.

Philipp the Magnanimous' reform programme also extended to begging. In theory, all begging had been prohibited in Hesse under the Reformation Order in 1526. This act forbade any 'foreigner' to enter Hesse, unless they were weak or infirm. Amongst 'natives', however, 'every town or village shall support its own poor, needy people for God's sake'.[30] The influence of Lutheranism is evident throughout such reforms - such sentiments are echoed in Luther's 1520 pamphlet, *To the Christian Nobility of the German Nation*.[31] The numerous references to begging within the Hessian petitions suggest however that the chronically sick and disabled were considered legitimate recipients of such aid. On a communal basis, poor relief was established in the form of community chests, whereby each parish should provide alms for their poor.[32] The 'Landgravely Command' of 1527 stated that: 'It is still his [the Landgrave's] command [that] common chests be

[28] Wright, Capitalism, p. 191.
[29] LWV, Hospitals-Ordnungen und Vergleiche, (Haina), Hospital Ordnung von 1535'; see also StAM, Bestand 17I, Nr. 2366.
[30] Wright, Capitalism, p. 171.
[31] Ibid, p. 171.

set up among you, everywhere in towns and villages..., which will be administered in common by five men and thus, alms be distributed by them to house poor persons, needy broken people'.[33] One of the main aims of this project was 'the improved care of persons suffering from infirmity and the ailments associated with old age'.[34]

It is evident that the establishment of the *Landesspitäler* was part of a much wider plan for the re-organisation of state relief measures within Hesse. Political and religious motivations also influenced these policies. Those government officials who were initially involved in the hospital establishment process (such as Heinz Lüder and Adam Krafft) were also both involved in surveying and assessing the religious climate of the territory, and were responsible for organising groups of preachers to spread the word of the reformed religion throughout the state. Similarly, in order to gain entry into Haina or Merxhausen one had to have led a pious life, and to either follow Protestantism or be ready to convert. In 1719, for example, a lame and frail Jewish girl from Koblenz was granted a place in Hofheim Hospital provided that she 'convert to Christianity'.[35] As will be shown in Chapter Two, the pastor played a central role in the running of the hospital, especially in the sixteenth- and seventeenth-centuries. His authority was only surpassed by that of the hospital superintendent (*Obervorsteher*). Recourse to prayer and Bible readings played a large role in the daily life of the hospital, and it was (theoretically) expected that patients would learn some of the main prayers and catechisms by heart.

It is however perhaps too simplistic to explain the Landgrave's actions merely in terms of politics and religious issues. Benevolence also played a part. After all, the poverty of this area of Germany cannot be denied. One is able to glean an impression of late sixteenth-century Hesse-Kassel from the commentary of the sixteenth-century English traveller, Fynes Moryson. A Protestant, Moryson 'cited

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[32] See especially, Walter, 'Armen', pp. 1-20.
[33] Wright, Capitalism, p. 187.
[34] Schenk, Geschichte, p. 4. The translation / paraphrasing is my own.
[35] LWV, Bestand 13, Reskripte, 1719. Also referred to in Mittelrhein-Museum Koblenz in Verbindung mit dem Stadtarchiv Koblenz (hrsg.), Große Leute – Kleine Leute. 2000 Jahre Koblenzer Geschichte, Katalog zur Ausstellung im Haus Metternich, 12. 5. – 2. 8. 1992, Koblenz, 1992, p. 61.

a common doggerel of the era': "High Mounts and Valleys deepe, with grosse meates all annoide / Sowre wine, hard beds for sleepe: who would not Hessen land avoide?"[36] Of the towns of the territory he stated, " The houses were of timber and clay, each one for the most part having a dunghill at the doore, more like a poore village, then [sic] a city; but such are the buildings in the cities in Hessen."[37]

To his contemporaries, as indeed to many today, Philip the Magnanimous was regarded as a benevolent innovator - the 'Christian prince of Hessen-Land', the 'beloved hero', who 'stretched out his charitable hand'. As will be detailed in Chapter Three, this was, however, a position that he coveted. Recognition of the importance of the role of Landgrave Philipp in instigating these reforms was not confined to Hesse. A letter from one of the Landgrave's officials on 18th February 1573 illustrates this point. The correspondence relates to the request of an official from the Palatinate (at the behest of the Elector), that he be sent a copy of the Haina Hospital foundation ordinance, as the ruler was considering establishing a similar institution in his territory.[38] The popularity of the *Landesspitäler* is also evinced in this document. It states that 'currently' (i.e. in 1573) approximately 800 'suffering and infirm' people were residing in the four hospitals. This was in spite of the fact that Haina, the largest and richest of these institutions had only ever been intended to house 100 persons. The numbers had, instead, now exceeded 300 in Haina alone.[39]

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[36]Moryson, Fynes, An Itinerary Containing His Ten Yeeres Travell Through the Twelve.....Netherlands, Denmark, Poland, Italy, Turky [sic], France, England, Scotland, and Ireland, volume 3 (Glasgow, 1907), p. 455. Cited in Theibault, German, 1995, p. 8.
[37] Moryson, Itinerary, p. 72. Cited in Theibault, German, p. 9.
[38] Demandt, 'Anfänge', p. 195.

IV. Theory and practice. The ordinances of Haina and Merxhausen.

The earliest years of the history of the *Landesspitäler* have been covered in some depth by two studies of Karl Demandt from a largely bureaucratic perspective.[40] This period has also been summarised in the work of Paul Holthausen.[41] Studies written in English and which focus solely upon Haina are located in three papers written by H. C. Erik Midelfort.[42] Many other brief articles exist in Germany regarding the earliest statutes – most notably in localised publications. For the most part however, the latter offer little more than a transcription of the documents. Analysis, where it exists, is scanty. While it is not the intention of this thesis merely to repeat such work, some reference to these early documents is, of course, necessary. Research to date has tended to brush over the later sixteenth- and seventeenth-centuries, focusing specifically upon the sources relating to the foundation period before skipping to the next major re-structuring, the ordinance of 1728. The latter also usually elicits only a brief comment. The situation is neatly summarised in some of the remarks made by Arnd Friedrich in his essay of 1983, *Die Hohen Samthospitäler in Hessen vom Tode Landgraf Philipps des Großmütigen im Jahre 1567 bis zum Beginn des 19. Jahrhunderts.*[43] Friedrich comments that his survey of the historiography of the hospitals had led him to conclude 'that no coherent study has [yet been] presented concerning the long period of joint administration [*Samtverwaltung*, detailed below] of the four 'high hospitals' of Haina, Merxhausen, Hofheim and Gronau'.[44] Since that time, no other comprehensive study of this time frame has been offered.

It is the intention of this section of the thesis to offer a brief, but comprehensive, overview of the administration of Haina and Merxhausen from their conception to the early eighteenth-century. References will primarily stem from ordinances and other correspondence relating to policy-making. Three main orders (*Ordnungen*) exist in the period from the sixteenth- to the eighteenth-centuries –

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[39] Ibid, p. 195.
[40] Ibid, pp. 176 – 235; Idem, 'Hohen', pp. 35 – 134.
[41] Holthausen, Landeshospital.
[42] Midelfort, 'Protestant', pp. 71 – 94; Idem, 'Sin', pp. 113 – 145; Idem, Madness, pp. 332 – 385.
[43] Franz, 'Hohen', in Heinemeyer & Pünder (eds.), 450 Jahre, pp. 135 – 160.

1535, 1573, and 1728. These were written by the superintendent (*Obervorsteher*), who was in charge of all of the four hospitals and they generally relate to the day-to-day running of the establishments. This thesis will also use evidence found in correspondence *(Abschied)* amongst the Landgraves or between the superintendent and the rulers. A study of these documents will reveal both the continuities and also the divergences that occurred from the original documents of the 1530s. Although a major re-working of the 1535 foundation order was not undertaken until 1728, it was widely acknowledged prior to this date that the realities of the hospital administration differed (in many cases substantially) from the provisions laid down in the sixteenth-century.

i. The foundation ordinances.

Landgrave Philipp commissioned the *Obervorsteher* of the territorial hospitals, Heinz von Lüder, to draw up the first set of regulations for these institutions in 1535.[45] As a brief glance at the resulting document reveals, it was intended to be comprehensive, dealing with the majority of aspects of institutional life – concerning the establishments both in their remit as hospitals and also as seigneurial rulers. This document – as indeed all of the main ordinances under consideration here – was intended to encompass all of the four state hospitals. Individual differences merely reflected the institution's name (i.e. Haina, Merxhausen, etc.) and the intended gender distribution of its patients. Thus the paperwork for Haina concerning its inmates read 'men' whereas that for Merxhausen stated 'women'. The 1535 ordinance can be divided into four main sections. It opens with a concise appraisal of the intended function of the hospitals. In the version written for Haina, Lüder stated that the hospitals had been founded to 'take in so many poor men, as many as one can always ...receive and provide for and the number [*hauffen*] of the poor [should] increase

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[44] Ibid, p. 135.

[45] For a detailed discussion regarding the exact dating of this document see Demandt, 'Anfänge' esp. p. 196ff; Demandt, 'Hohen', pp. 48 – 51. The latter article contains a transcription of what Demandt terms the Luder's '*Grundstatut*' of 1534. Apart from the occasional alterations in the wording, this document is essentially the same as the '*Hospital Ordnung von 1535*'. It appears to be an eighteenth-century transcription. (LWV, Hospitals-Ordnungen und Vergleiche).

until it reaches one hundred poor men'.[46] It was also ordained 'that such poor people should come every now and then [*hin und wieder*] principally from the villages in the principality and not from the towns, and that these same poor people should be taken in according to God's will and for no other reason than poverty and need, and not as a result of favour, friendship, [or] gifts [*Gaben und Geschenck*] ... and no-one under the age of sixty years should be accepted. Were this the case, it would be a person so infirm that he is otherwise unable to earn his bread and nourishment through work, [and] is capable of no form of service. And because alms should first and foremost be dispersed [*mitgetheilt*] among needy Christians, so it is also Christian, just and of necessity that these poor people should be cared for in the hospital [*Spital*] [and that they] should also live according to a Christian code of conduct [*in Christlicher Ordnung leben*]...''[47]

The second part of the document gives a detailed account of the daily routine that it was envisaged that the *Hospitaliten* (inmates) should adopt. All of the stipulations were geared to 'leading an honourable way of life'. The next section is a relatively brief discussion relating to 'the celebration of Holy Communion'. It is followed finally by instructions relating to the duties of those in charge of managing the hospitals (the *Hospitalleitung*). It largely confines its attention to the roles of the governor (*Vorsteher*), the master of the hospital (*Spitalmeister*), the bursar (*Rentschreiber*) or housekeeper (*Schaffner*),[48] the pastor (*Prädikant*) and the head forester (*Holtz-Förster*).[49] The opening section of this order summarises the authorities' (that of the superintendent and presumably also the Landgrave) 'vision' of the hospitals in their most fundamental sense.

The state hospitals were primarily established to cater for the sick poor in the Hessian countryside who were either over the age of sixty or whose infirmities meant that they had no other means of supporting themselves, either by their own actions, or through the assistance of others. Landgrave Philipp determined in the

[46] LWV, Bestand 13, Hospitals-Ordnungen und Vergleiche, (Haina). Hospital Ordnung von 1535; StAM, Bestand 17I, Nr. 2366.
[47] LWV, Bestand 13, Hospitals-Ordnungen und Vergleiche, (Haina). Hospital Ordnung von 1535; StAM, Bestand 17I, Nr. 2366.
[48] Demandt refers to this person as the '*Helfer der Spitalmeister*'. Demandt, 'Hohen', p. 52.
[49] Another copy of this ordinance also included, among others, the porter and the *Teichmeister*. StAM, Bestand 17I, Nr. 909.

foundation letter of 1533 that he was commanding 'our heirs and successors ... to protect and uphold ... this our foundation'. Was this order realised, and if so, how?

ii. The legacy of Philipp the Magnanimous.

Prior to his death in March 1567, Landgrave Philipp the Magnanimous decreed in his last testament of 1562 that Hesse was to be divided among his four legitimate sons Wilhelm IV, Ludwig IV, Philipp the Younger and Georg.[50] As the eldest, Wilhelm IV would inherit Lower Hesse (Hesse-Kassel). Ludwig IV would take Upper Hesse (Hesse-Marburg), Philipp the Younger would rule the Lower County of Katzenelnbogen (Hesse-Rheinfels) and Georg would be allocated the Upper County of Katzenelnbogen. In spacial terms, Wilhelm IV's inheritance constituted approximately one half of the total state. An area of 6100 square kilometres, it had approximately 190,000 inhabitants. By contrast, Hesse-Marburg equated to one quarter, while the combined mass of Hesse-Rheinfels and Hesse-Darmstadt amounted to the remaining quarter.[51] The line of Hesse-Rheinfels died out in 1584, and that of Hesse-Marburg in 1604. After this date, Hesse was divided between the two remaining houses, Hesse-Kassel and Hesse-Darmstadt. From this point onwards the houses of Hesse were locked into disputes regarding the division of land and also religious practice. The disagreement (known as the *Bruderzwist*) culminated in the brothers declaring war against each other in the so-called *Hessenkrieg* that occurred amidst the Thirty Years War. Peace was finally restored in 1650.[52]

The potential effect of these disagreements on the territorial hospitals can be realised when one considers the other terms of Landgrave Philipp the Magnanimous' testimony. Philipp ordained that an array of charges and

[50] For more information, see Demandt, Karl E., 'Die hessische Erbfolge in den Testamenten Landgraf Philipps des Großmütigen und der Kampf seiner Nebenfrauen um ihr Recht', Hessisches Jahrbuch für Landesgeschichte, 17, 1967, p.138f; Press, Volker, 'Hessen im Zeitalter des Landesteilung (1567 – 1655), in Heinemeyer (hrsg.), Werden, pp. 267 – 332.
[51] Demandt, Geschichte, p. 238.

privileges were to remain jointly owned by the brothers. Thus, although geographically divided, Hesse was to work as one state within certain areas of government. Among these were the University of Marburg, the archive (*Samtarchiv*), the High Court (*Samt Hofgericht*) and the four 'high hospitals' [*Hohen Hospitäler*] - Haina, Merxhausen, Hofheim and Gronau.[53] Whereas, during the *Bruderzwist*, institutions such as the University of Marburg became separate institutions, run by only one of the Landgraves, the hospitals always remained true to the founder's wishes, and were ruled jointly.[54]

Philipp the Magnanimous had already addressed the issue of the joint rule of the state hospitals in 1555. In a *Bestätigungsbrief* of the same year, the brothers promised that they and their heirs would continue to run the hospitals according to the wishes of their father.[55] They would thus 'protect and keep' these foundations and would dedicate themselves to ensuring that the establishments suffered 'no shortages or damages [*keine Mangel oder Abbruch*]'. The hospitals were to improve, and the brothers pledged to ensure that their successors continued these traditions. As their father has envisaged, the institutions were to become an 'everlasting endowment [*ewige Stiftung*]'.[56] Surviving documentation reveals that the brothers repeated the promise of 1555 in 1568.[57] It re-appeared in a similar fashion in pledges made by both Landgrave Moritz in 1595, and by Landgrave Ludwig in 1599 at the point of their entry into government.[58]

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[52] The constraints of the thesis prevent a detailed analysis of these events. For more information, see Beck, K., Der hessische Bruderzwist, 1978; Idem, 'Der Bruderzwist im Hause Hessen', in Schultz, (hrsg.), Geschichte, Stuttgart, 1983, pp. 95 – 105

[53] For further details, see also, Demandt, Geschichte, p. 238.

[54] Beck, 'Bruderzwist'.

[55] LWV, 'Bestätigungsbrief der Landgrafen Wilhelm, Ludwig und Philips vom 4/12/1553', in Hospitals-Ordnungen. Another version of this document (containing minimal variations in the wording) can be found in StAM, Bestand 17II, Nr. 2699 The signature of Landgrave Georg was secured at a later date as he was not old enough in 1555 to be capable of ruling (*rechtsfähig*).

[56] LWV, Hospitals-Ordnungen und Vergleiche, (Haina). Bestatigungsbrief der Landgrafen Wilhelm, Ludwig und Philips von 4/12/1555.

[57] Rommel, Chr., Geschichte von Hessen, Band 1, 1835, p. 139ff. Quoted in Friedrich, 'Hohen', p. 137.

iii. Joint administration.

Philipp the Magnanimous' successors were expected to maintain not only the initial foundation premise of the hospitals, but also the terms of the 1535 ordinance compiled by Lüder. The first surviving order after Philipp's death was written in 1573 by the superintendent of the time, Reinhard Schenk.[59] As in 1535, it was intended to cover administration within the four hospitals. Essentially, after stipulating similar aims regarding the perceived remit of the institutions' care as were found in the earlier source – poverty, ill health, an inability to work, etc – it turned to instructions for hospital employees (*Dienstinstruktionen*) relating to individual positions within the hospital. Whereas the 1535 document was broad in its scope, including both hospital life and also the duties of employees, the 1573 version concentrated primarily upon the latter topic. In terms of the basic motivations for the hospitals' foundation ostensibly little had altered. Thus in the 1573 preamble, Schenk stated that Landgrave Philipp the Magnanimous, acting out of a 'particularly Christian enthusiasm' and a out of a concern about poverty in Hesse 'had allocated [*bestimmt*] the four places of worship [*Gotteshaüser*] Haina, Merxhausen, Hofheim und Gronau to provide the necessary maintenance for poor, weak and infirm [*gebrechlich*] persons of both sexes, who were unable to earn their bread any longer [*die ihr Brot nicht mehr verdienen können*].' He proceeded to recount how Philipp had passed his duties onto his sons, so that the hospitals could continue to function 'in the same manner'.[60]

These bureaucratic aspects were further expanded in the instructions of 1576, written by the four brothers. Concentrating upon economic issues, the document's appearance can perhaps, be viewed as an extension of Wilhelm IV's wider plans to form an 'economic state'.[61] It advocated an increased awareness on the part of the institutions regarding all aspects of their finances ranging from daily administrative costs to their possessions within the affiliated provinces

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[58] LWV, Hospitals-Ordnungen und Vergleiche (Haina) Bestätigungsbrief des Landgrafs Moritz 26/02/1595; Bestätigungsbrief des Landgrafs Ludwig, Darmstadt 01/05/1599.
[59] German transcription in Demandt, 'Hohen', pp. 79 – 88.
[60] Ibid, pp. 79 – 80.

(*Vogteien*). Through this scheme, such matters could be kept in check not only by the hospitals themselves, but also by the state. Similar concerns had been in evidence earlier in the instructions regarding the establishment of the Haina *Salbuch* in 1556. Here, the importance of discovering the hospital's exact financial position – especially with regards to the lands it owned, and the rents it was due – was stressed.[62] The continued relevance of such examinations was clearly exemplified in the order of 1576, which called for yearly visitations of the hospitals. Invoices (*Rechnungen*) of all monies and produce received and expended by the institutions had to be checked and thoroughly accounted for in a weekly, quarterly and yearly format, for which 'the pastor and all officials' were responsible.[63] A government commission audited these financial records, visiting Haina once a year – from at least 1627, the date was set for May 1st.[64] It is clear therefore, that although the hospitals were theoretically self-financing and had been envisaged as a fundamental part of a wider project to cater for the 'common good', their autonomy (if, indeed, it had ever really existed) was limited. Quintessentially, these establishments were state possessions, reliant on state finances to bail them out of any economic disaster. As such, they were continually answerable to the authority of the Landgraves and, increasingly, to the government visitation commissions.

The evidence from the ordinances suggests that little changed in the *Landesspitäler* during the sixteenth-century. One of the results of the *Bruderzwist* between the lines of Hesse-Kassel and Hesse-Darmstadt was the *Abschied* dated 14th December 1627 which related to the fate of the *Hohen Hospitäler* amidst the wider conflicts.[65] The Landgraves acknowledged the necessity to prevent 'further mistakes [*irrungen*] and misunderstandings

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[61] Krüger, Kersten (hrsg.), Der Ökonomische Staat Landgraf Wilhelms IV. Dritter Band. Landbuch und Ämterbuch, VHKH, Band 17, 1977.

[62] LWV, Bestand 13, Hospitals-Ordnungen und Vergleiche, (Haina). Instruction zur Aufstellung des Salbuchs 1556.

[63] Regarding this, see, for example, LWV, Bestand 13, Hospitals-Ordnungen und Vergleiche, (Haina). 'Hospital Ordnung, Milsungen 1st Januar, 1575 von der Landgrafen Wilhelm, Ludwig, Philips und Georg'.

[64] For a brief overview of the visitation process, see Friedrich, 'Hohen', pp. 158 – 160. Regarding the May date, see, LWV Archiv, Hospitals-Ordnungen, 'Abschied zwischen Landgraf Wilhelm und Georg, Marburg den 14. December 1627 die 4 hohen Hospitalien betr.'

[65] For more information relating to the end of the Hessenkrieg and the 1627 Abschied see the brief summary of Demandt in Idem, Geschichte, p. 261.

regarding the inspection, visitation, administration and other issues' relating to the institutions.[66] The *Abschied* is essentially a detailed confirmation regarding the finer points of joint rule. The houses of Hesse-Kassel and Hesse-Darmstadt were to take it in turns to be in charge of various aspects of the bureaucracy of the institutions. Thus, for instance, one house would be in charge of the yearly visitations and this duty would then pass to the other house the following year. Hesse-Kassel was to commence this policy in May 1628. Appointments within the hospital – especially that of the *Obervorsteher* – were to be similarly divided. Of interest to us here, however, is the ninth point of the article which deals with the hospital inmates and which voices many of the earlier concerns regarding the application process. 'So that ... the hospitals will not become over-run with poor people... no person was to be transferred into one of the high hospitals...' until an official *(Beambte)* had checked to see if the person was worthy *(fehig)* of alms according to the terms of the foundation decree. Should any 'unworthy' persons be found during the yearly visitations, the individual should be ousted, and a report should be sent to the territorial princes (the Landgraves).[67] At all other times, the *Obervorsteher* or the governor of the hospital should advise the prince and the 'imposter' should leave the hospital.[68]

It is unclear whether the Thirty Years War (1618 – 1648) and the *Hessenkrieg* had rendered the good intentions of the 1627 agreement ineffective, or whether, in the spirit of peace, the two houses decided upon another document that advocated joint administration of the hospitals. Following the end of both wars in 1648, a decree was agreed between the Landgrave Georg of Hesse-Darmstadt and the Regent Landgrävin Amelie Elisabeth of Hesse-Kassel in 1650.[69] It was

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[66] LWV, Bestand 13, Hospitalsordnungen, 'Abschied zwischen Landgrafen Wilhelm und Georg, Marburg den 14. December 1627 die vier hohen Hospitalien betreffend'. Also in Anon, Gruendliche und Warhafte Beschreibung der Fuerstenthuemer Hessen und Hersfeld ..... Aus den glaubwuerdigsten Documenten und Scribenten in Sechs Theilen verfasset. Aber vors erste werden Fuenf Theile publiciret, Bremen, 1697, pp. 557 – 561. Friedrich refers to a *Vertrag* dated 24 September 1627. While references to this document are made in the sources under consideration here, both copies of the source that I have found to date are from 14th December 1627. (Idem, 'Hohen', p. 141.)

[67] Anon, Gruendliche, p. 560.

[68] Ibid, p. 560. More details re. the 1627 Abschied can be found in Friedrich, 'Hohen', pp. 140 – 142.

[69] For a brief discussion see, Demandt, Geschichte, pp. 263 – 264.

essentially a repeat of its 1627 predecessor.[70] Nevertheless, the renewed peace that accompanied this document has led the historian Arnd Friedrich to deem this to have been the most important order since the 1533 foundation. Its basic stipulations lasted until the nineteenth-century.[71]

iv. Continuity or change? Eighteenth-century administration of the *Landesspitäler.*

Were we to rely solely on the evidence of the bureaucratic documents, we would obtain the impression that the administrative history of Haina and Merxhausen was primarily characterised by a long period of continuity, stretching from the hospitals' conception until the early eighteenth-century. We would conclude that the clientele of the hospital remained true to the original conception of Landgrave Philipp from the original foundation letter of 1533 – or, more realistically, from the more detailed first hospital order of 1535. The re-worked rules of 1728 suggest a different perspective, however. In its draft version of 1727, written by the *Obervorsteher* at that time, William von Urff, we learn that discussions had commenced in 1723 regarding the outdated nature of the available documentation of the time. 'As circumstances have changed over a long period of time, the hospital ordinance is no longer applicable in all [of its] parts...'.[72] An updated version was thus required. The 1723 ordinance was intended for Haina alone. Intrinsically, the new order mirrored earlier documents. The main changes related to the hospital employees – for instance, the individual who was formerly called the '*Spitalmeister*' or '*Pater*' was now referred to as the '*Amtsvogt*'.[73] The 1728 Renovated Order [*Renovierten Ordnung*] for the three hospitals and their provinces stemmed from the same motivation as its 1723 predecessor. A large amount of space was devoted to instructions for hospital staff and also for those people employed in establishments owned by the *Landesspitäler*. It is clear that the primary reasoning behind the 1728 ordinance

[70] Schlieper, Edith, 'Die Ernährung in den Hohen Hospitäler Haina und Merxhausen im 16. Jahrhundert', in Heinemeyer & Pünder, 450 Jahre, p. 236.
[71] Friedrich, 'Hohen', pp. 141 – 143.
[72] LWV-Archiv, Hospitals-Ordnungen und Vergleiche, (Haina), 1727 'Examplar... Neuer Hospithals Ordtnung'.

related to economic considerations. We learn that, in comparison to Philipp the Magnanimous' original intentions, 'there are currently seven hundred people being cared for in ...our hospitals [*Samthospitalien*]'. In the past 'thirty or forty years' the inmate population had increased by two thirds.[74]

The 1728 order illustrates some of the concerns and problems that the institutions had presumably experienced in relation to the admissions process. In a letter of 10th April, 1728, Landgrave Carl suggested that mistakes had been made in the past, which were partly a result of the pastors, officials, and the visitation commissioners failing in their duty. Carl believed that 'through dissimilar [*ungleiches*] testimonies such people who are not worthy enough [*nicht gnugsam fähig*] of admission have sneaked themselves in to... our *Samt-Hospitalien...*'. The Landgrave requested confirmation 'that [such] misuse and [the] terrible state of affairs [*Misbrauch und Unwesen*] ...' would 'once and for all ... [be] abolished and totally eliminated'. He was especially alarmed by the number of 'pensioners' [*Pfründner*] who were in the hospital, and was worried that 'many poor and old and ... particularly wretched and infirm people' were going unnoticed so that, while waiting for assistance they 'instead in the meantime ... die helpless in their misery...'

The 1728 ordinance was as an attempt to regulate the admissions procedures. It implied that a failure to comply with these rules would result in (unstipulated) punishments for all parties involved. The main issue concerned urban inhabitants. The ordinance stated that the policy towards this matter remained unchanged. Namely, 'that the poor and the infirm [*Preshaften*]... [from the towns] are not [allowed to be] received into our High *Samt=Hospitalia* but must instead either be cared for in the particular [*particulier*] hospitals of each place or must be maintained from a collection of a poor rate [*colligiren den milden Steuren*] amongst the wealthy inhabitants The one exceptional case [is found] where ... [a person] is to be found in such [a] rage and [a] fury [*in solch Wuth und Furorem*], that ... [it would not be possible] to keep [him or her] without a particular danger to the place...'. It was the responsibility of the Ministry,

[73] Friedrich, 'Hohen', p. 145.
[74] Ibid, p. 145.

officials, and *Burgermeister* and Council [*Rath*] to specify the type of *Furor* from which this individual was suffering.[75] This distinction between the degrees of madness should be made 'with [the] input [*Zuziehung*] of the town physician, or of an enlisted medic [*eines verpflichteten Medici*]'. Individual cases were to be studied before a petition was made. The accompanying reports were to include answers to the following questions:

(1) 'In what does the fury actually exist? [*worin die Raserey eigentlich bestehe*?]

(2) How long has it already lasted?

(3) Whether it is in all appearances incurable?'

Questions four to six related to financial matters:

(4) 'Whether and how much the nonsensical [*unsinnige*] person has *in bonis*?

(5) Whether this person could either maintain themselves [i.e. pay for their own upkeep] in our hospitals?

Or (6) whether their parents or siblings ...could fund [*fourniren*] such care costs [*Verpflegungs=Kosten*]?'

Stipulations were also made concerning points that were to be addressed in the reports of the officials and pastors. Although the authors of these reports were lay persons, the questions retained a medicalised slant. The order stated that the 'officials and pastor ...must specify in their testimony ...how far the illness [of the invalid in question] affects the mind or the inner section of the body [*die innerliche Theile des Corpers*, sic]'. Additional information that was required was as follows:

(1) 'How old is the supplicant?

(2) Whether he / she has any wealth, and if so, how much?

(3) What sort of constitution they have with their infirmity [*was es mit deren Gebrechlichkeit vor eine Beschaffenheit habe*] and whether they are [thereby] unsuitable for all types of work?

(4) Whether through the use of 'useful' [*diensamer*] medicine it would be possible to help this person?'[76]

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[75] Also written *'Fori'*.

[76] StAM, Bestand 17II, Nr. 930.

The 1728 ordinance marks a decisive break in terms of the hospital legislation. It must be noted, however, that it is in many respects a reactionary document, attempting to bring some order to proceedings, rather than a mark of innovation. It highlights the Landgraves' continual fear – possibly not unfounded – that 'unworthy' patients could fudge the application procedure and enter the hospitals. As will be seen later, many earlier applications already met the criteria stipulated within this order. This source should thus be read to a large extent as a confirmation of the ideals as found within the sixteenth-century foundation and as an attempt by the Landgraves to restore a measure of order over the admissions proceedings. In this sense, the original 'vision' had not changed. The question must now be asked: how far do the sources considered above match what we know to be the reality of the situation?

V. Internal concerns. Overcrowding and the flexibility of the admission process.

A formal acknowledgement of the need for a revised ordinance finally occurred in the 1720s, resulting in the 1728 order. Nevertheless it is clear that from the outset the terms of the 1535 ordinance were quickly broken in many fundamental ways. The net was widened so that more people would be eligible for care within the *Landesspitäler* than was initially intended by the founder, Philipp the Magnanimous. Those who were able to gain admission quickly numbered more than the frail and elderly infirm mentioned in the 1533 ordinance.

The three main areas in which admissions expanded were in the categories of urban patients, married couples and children. Admission was initially only given to an inhabitant of a town if they were suffering from a mental illness. Later, however, it also involved the physically ill – a matter that has hitherto been ignored by historians. Each of these groups will receive comment at various points throughout this thesis, but some of the main issues will be addressed here.

First, entry was frequently granted to patients under the age of sixty. By 1723, younger patients made up a substantial number of the inmates. From the outset,

those urban mental patients that were deemed dangerous and could find no comparable care within the towns were admitted. Not only did Haina's geographical location offer an isolated point of refuge for these patients, but, as an account from 1588 reveals, the hospital was equipped with 8 iron cages in which the 'dangerous mad' could be confined. These patients were to be admitted upon payment to the hospital. In certain cases, their admission was granted on condition that the town in question accepted a poor person into their urban hospital - to all appearances, a straight swap.[77]

In his study of the patient lists from Haina in 1538 and 1540, Karl Demandt has revealed how quickly inmates from urban areas were accepted - although, as he states, these were probably cases relating to mental illness. In these years, when the place of origin was given, fifty-two different villages and eighteen towns were named. In addition, there were two people who were recorded as coming from a town in the Nassau region (Freudenberg and Herborn) and another two who came from areas in the Rheinland (Mainz and Speyer). These latter examples are particularly interesting as not only would these petitioners have been non-rural residents, they would also have been '*frembden* [sic]' (foreigners), and should thus have been doubly unacceptable for admission. (As we do not know the precise details, emphatic conclusions cannot be drawn, as it may be that they had some other connections to Hesse that a mere list would not reveal. For instance, Demandt believes that the two men from Mainz and Speyer could have been former Haina monks.) Within Hesse, a relatively wide range of towns were mentioned – Alsfeld, Battenberg, Eschwege, Frankenau, Grebenstein, Grünberg, Hofgeismar, Immenhausen, Kassel, Kirchhain, Marburg, Neukirchen, Nidda, Rotenburg, Rosenthal, Staufenberg, and Wanfried. (See Figure One for the location of some of these places within relation to the *Landesspitäler*.) Studying the villages from which the petitioners originated, it is clear (and perhaps unsurprising) that the vast majority of them are situated in the areas around Haina. Villages in the districts of Frankenberg, Jesberg, Rauschenberg, Wetter, Battenberg and Neustadt are particularly well

[77] Demandt, 'Hohen', p. 67. Demandt cites a case whereby Landgrave Wilhelm agreed to admit an insane (*verrückt*) patient from the town of Grebenstein and the town stated that it would take a poor villager (*Dorfarme*) in his place.

represented. In contrast, numbers decrease dramatically when we move to areas over the Lower- and Upper-Hessian borders. No inmates came from areas in the east or north of Hesse. Demandt suggests that this was probably relating to the limited 'fame' of Haina as a hospital at this time – after all these lists were compiled less than a decade after the hospital's foundation.[78] More research is needed in order to ascertain if and how this changed over the years, and also to discover some possible reasons for these changes.

Admission of the 'urban mad' was, theoretically, in direct contradiction to the terms of the foundation stipulations. Historians have frequently commented upon the fact that the numbers of mental patients increased throughout the period under consideration here – not all of these persons came from towns however.[79] A manuscript dating from 1720 which (to my knowledge at least) has to date not been used by historians, offers a wider view of the 1533 admissions policy however. It states that this sixteenth-century document included the comment that the institutions were designed for 'the support of the abandoned wretches [*Elenden*], poor, lame, blind, sick, insane [*wahnsinnig*], naked, young and old persons, [both] male and female...'[80] Obviously one has to treat this document with care. More research needs to be undertaken to ascertain if this statement is correct – although other points of this historical overview can be corroborated through additional sources. Were this correct, however, it would explain the strange inclusion of the term 'first and foremost [*vornehmlich*]' within the sections of hospital orders which stipulate that the poor should come from the villages. It does not sufficiently explain, however, why these comments were not repeated in subsequent hospital ordinances when the other central points of the foundation letter were included. Only further research can answer such questions.

[78] Demandt, 'Hohen', p. 67.
[79] See among others, Midelfort, Madness, p. 356.
[80] Murdhard'sche Bibliothek, Kassel, 2o Mss. Hess.429[2

i. Married Couples.

Although it was theoretically forbidden for married couples to be in the same institutions, evidence suggests that from the outset this rule was frequently broken. Midelfort states that 'this exception to the original rules became so common that a commission of inquiry in 1627 reported complaints that the married now numbered '40, 50, 100, and even sometimes more than that'.[81] The hitherto unused 1720 manuscript sheds a different light on the situation however. This source offers a fragmented history of Haina, including the 1627 investigation as detailed above. The document suggests that the '40, 50, 100' comment originally related not to the numbers of married people in the hospitals, but rather concerns the amount of *gulden* that the individuals paid to secure their entry.[82] This would seem to be the most likely explanation – especially if one casts an eye over the lists of hospital patients during this period. An additional bone of contention lay in the fact that through the act of paying, these inmates enjoyed privileges that other patients were not party to. For example, such couples insisted on eating before the poor brethren. Evidence from Hofheim suggests that some of the married couples were also able to live in 'special rooms' (*sonderliche Stuben und Cammern*).[83] Their payments would accord them a special status as '*Pfründner*' (pensioners).

Not all married couples either applied for or were granted places in the same hospital however. In 1699, for instance, Steffan Meÿer, an elderly shepherd (*Schaafmeister*) at Merxhausen, requested that he and his aged wife be admitted into Merxhausen 'because of his age and his sickly disposition'.[84] In 1596, 'Anna, the wife of Hans Ammenheuser, asked to join her husband, who was already in Haina, for now she was so old, lame and poor that she could not earn anything. Instead of remanding her to Merxhausen, Landgrave Ludwig ordered

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[81] Midelfort, 'Protestant', p. 85.
[82] Murdhard'sche Bibliothek, Kassel, 2o Mss. Hess.429[2. This discrepancy highlights problems that can arise when more than one account of a single event exists.
[83] LWV, 'Rescript vom hl. Landgraf Ludwig de anno 1672 samt darauf erstatteten bericht die reception den hospitaliten und deren Vermoegen betreffend'; Various. Rescripte und Berichte, uncatalogued.
[84] LWV, Bestand 13, Reskripte, 1699.

her to join her husband in Haina.'[85] Couples clearly did not automatically expect to be allowed into the same hospital. In the 1698 petition of Henrich Meÿers from Deisell, he requested that he and his decrepit (*abgelebt*) wife were taken into Haina. He was 73 years old, and his spouse was 84 years of age. They were impoverished and physically incapable. Were his request not met, he wished to be taken into Haina and his wife into Merxhausen. The records reveal that they were both received into Haina later that month.

While some elderly couples may have been using the state hospitals as a form of retirement home, others clearly applied to the institutions out of poverty and old age. In some cases they were both allowed to go to either Haina or to Merxhausen, in other cases they were separated. Some spouses accompanied their partner in the form of their carer, or they worked within the institution in some capacity. It must be borne in mind, therefore, that the presence of a married couple within the patient lists did not necessarily signal a case of preferential treatment in the form of a retirement contract. Nevertheless, economic concerns were frequently of great importance – especially in a period in which the hospital was permanently overflowing – and these issues were often instrumental in widening the net of the application process.

ii. Children.

'Foundlings and poor, fatherless children' gained entry into Haina from the late 1570s, if not before. They were to be taught 'to read and write, and also to 'work diligently', so that 'when they reached twelve years of age' they could leave the hospital to work as servants or apprentices, instead of remaining in the hospital being irksome, and acting like 'lazy gallows-birds'.[86] A list of Haina hospital inmates (*Hospitalinsassen*) from 1577 indicates the presence of such children. We learn, for example, of Hebel Moller, a mute and frail boy who was aged six years old. Resident in the neighbouring village of Löhlbach, his father, Kurt

[85] Midelfort, 'Protestant', unpublished manuscript held at LWV Archiv. I am yet to find the original document, dated March 1596 (Reskripte).
[86] Wickel, Geisteskrankenpflege, September 1933, p. 130.

Müller [sic], a poor widowed day labourer had petitioned Landgrave Ludwig to take in Hebel, his youngest child.[87] In the same year, four foundlings (*Findlingen*) were accepted. All were male They included a blind boy named Adam, and three other children – Heinz Funk, Johann Hirte and Johann Lummel.[88] As has been pointed out, the 1577 ordinance hints that Haina was deemed to be 'so attractive that even substantial families were tempted to leave their children there for schooling.' The order stated 'for it ought to be a hospital and not a school, especially since these children always eat the best food, which the poor, needy residents observe and endure with great bitterness'.[89] By 1586 the number of children in Haina appears to have increased dramatically. It is perhaps useful to briefly consider the details of those youths to gain a broader perspective regarding their place within the hospital ethos. The list is divided into three sections - those 'poor, minors [*unmündig*] and orphaned children' admitted by Landgrave Wilhelm in the first instance and by Landgrave Ludwig in the second, followed by those children who were transferred from Merxhausen hospital.

It reads as follows:

'... Landgrave Wilhelm...

- Tobias Klein from Burghasungen, a boy (*Knabe*) of 14 years.
- Klaus Weber from Heinchen in the district (*Amt*) of Spangenberg, approximately 9 years old.
- Kunz Schröder from Helmes in the district of Friedewald, a blind boy, 15 years of age.
- Abel Dreas from Roteman in the district of Homberg in Hesse, a boy of 14 years.
- Johannes Luckardt from Nassenerfurth in the district of Borken, a blind boy of 16 years.
- Zacharias Schwarz from Kassel, a poor boy, 10 years of age, received in 1582.

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[87] Quoted in Demandt, 'Hohe Hospitäler', p. 111.
[88] Ibid, p. 114.
[89] Midelfort, 'Protestant', p. 84; Friedrich, 'Hohen', p. 154.

- Johannes Thomas from Heßlar in the district of Felßberg, a boy of 15 years with a lame and frail (*gebrechlich*) arm.
- Jost Freytag from the ... district of Spangenberg, a poor, infirm boy, 16 years of age.
- Peter Wolf from Gleichen in the district of Gudensberg, a boy of 16 years.
- Kurt Moller from Calden (possibly Kalter) in the district of Kassel, a feeble (*gebrechlich*) boy. 16 years old.
- Henne from Körle in the district of Melsungen, a boy aged 7 years.
- Bernhard Herrgotts from Breitenbach in the district of Rotenburg, a blind boy aged 12 years. Received in 1583.
- Johannes Hoff from Vacha, a poor student with bad (*bösen*), frail (*gebrechlich*) legs. 22 years of age. Teaches the poor children to pray and will be used as reader in the rooms [*Stuben*]. Accepted in 1585.

... Landgrave Ludwig...:
- Johann Hirt from Herbelhausen in the district of Rosenthal. 12 years old. Received in 1581.
- Matthias Schmidt from Ernsthausen in the District of Wolkersdorf, a boy of 10 years.
- Johannes Gaden from Willersdorf in the district of Wolkersdorf, a boy aged 15 years.
- Kurt Klein from Dörnholzhausen ... in the district of Wolkersdorf, a boy of 8 years.
- Johannes from Münchhausen, a 6 year old lad (*Knabe*).
- Valentin Wacker from Holzhausen in the district of Rosenthal, a boy of 14 years.
- Johannes Schramm from Geismar in the district of Wolckersdorf, a boy. 8 years old.
- Johannes Bromm from Niederohmen in the district of Grünberg, a blind boy aged 7 years.
- Hermann from Geismar in the district of Wolckersdorf, a boy of 6 years.
- Georg from Neiderohmen, a boy with a goitre, approximately 12 years old
- Jakob Schneider from Niederholzhausen in the district of Rosenthal, a lame boy of 10 years.

- Johannes, a mute from Lotheim in the *Herrschaft* Itter, received in 1585.[90]

From the Hospital Merxhausen...

- Johannes, a foundling, roughly 10 years old.
- Kurtchen Reitz, approximately 9 years old.
- Johannes, a foundling of approximately 12 years of age.
- Klaüschen from Marburg, a child of 8 years.
- Henne Witzel from Neukirchen, a poor boy aged 8 years.
- Johannes from Holzhausen, a boy of 7 years.
- Johannes Dorbert from Reimershausen, a poor, infirm boy of 15 years.
- Hans Koch from Merxhausen, a poor boy aged 8 years.
- Hermann Webel from Haubern, approximately 6 years old. Received in 1585.
- Hermann Opel from Fischbach, a blind boy. 17 years old. Received in 1585.
- Ludwig Maus from Zierenberg, a poor boy who is somewhat deprived of his senses (*seine Sinne etwas beraubt*), aged 16 years.
- Immerlaut, a poor orphan (*Weyßlern*) aged roughly 8 years. Will be raised in the hospital and was received in 1584.'[91]

A brief consideration of this source is useful for several reasons. Firstly we learn that in this year, 38 children were residing in Haina. Admittedly, this is a diversion from the original ordinance in the sense that orphaned children were admitted whose sole reasons for application related to this status rather than to any chronic ailment. (The ordinance only allowed access to those under the age of sixty if their physical incapacity was sufficient to render them unable to provide for themselves.) We can perhaps argue that it was reasoned that these children were unable to support themselves by virtue of the incapacities connected to their age rather than to a specific affliction. Moreover, it must be noted that, until the eighteenth-century when an orphanage (*Waisenhaus*) was finally established in Kassel, there was no specific institution to cater for such children. Until this time, children were admitted into the territorial hospitals – in varying numbers. As will be discussed in due course, the *Landesspitäler* can

[90] German transcription in Demandt, 'Hohen', p. 124.
[91] Ibid, p. 125. See also StAM, Bestand 17I, Nr. 2195. Spellings of names and places of origin differ slightly in this source when compared to Demandt's transcription.

often be viewed as providing shelter for sectors of the population for whom neither the state nor private initiative had hitherto provided.

A more detailed discussion regarding the range of illnesses suffered by and also concerning the merits of the source material will be found in Chapter Two. Several points are nevertheless of note here. One of the most striking points relates to the fluidity of the terms 'child' or 'boy' as it was understood by the hospital. It is clear from the 1586 document that, during this year at least, not only were children relatively common in the hospitals, but the category of 'child' encompassed a far wider range of ages than those suggested by the ordinances and correspondence. These stated that any children admitted should leave the hospital by the age of eight or twelve (depending upon which document one consults).[92] Exceptions to this rule would only occur when an individual's medical condition prevented them from being self-sufficient. Nevertheless, it seems clear from the 1586 list that many exceptions to this rule existed. Many teenagers are noted here, with no reference being given to their physical and mental state that would suggest an incapacitating affliction. While we must not rule out the possibility that these were simply omissions on the part of the compiler of this document, it does not explain why in other instances, details relating to an individual's medical state were given. As will be shown in the next chapter, it is in such cases that the petitions offer a crucial method for us to commence the process of disentangling such queries.

iii. Overcrowding

In light of the evidence above, it is unsurprising that overcrowding was one of the greatest constant problems faced by the state hospitals from their conception until the first half of the eighteenth-century (and beyond). Midelfort, in his study of the early years of Haina, labels this factor 'the largest deviation from the original model'.[93] This dilemma is amply illustrated when one considers the following statistics: At the time of their abolition as monastic institutions in

[92] The 1577 ordinance gave the age of maturation as twelve years.
[93] Midelfort, 'Protestant', p. 85.

1527, Haina housed forty-one people, while Merxhausen had only twenty-seven.[94] The foundation ordinance stated that this number could increase to one hundred persons in each of the hospitals. A report of 1580 reveals, however, that the hospitals had quickly exceeded their intended limitations. A total of one thousand and eighteen persons were resident in the four state hospitals at the time. Gronau and Hofheim were the least affected – indeed the former housed eighty-five 'poor persons' and an additional twenty-two people who served the hospital in a variety of capacities [*diener vnd haußgesinde*]. Merxhausen and Haina catered for the lion's share, with the former having a total of three hundred and seventy-one persons and the latter three hundred and thirty-eight. An additional sixty-two persons worked at Haina.[95]

Abundant evidence exists which reflects the Landgraves' concern with this problem from the outset. In a correspondence of 12th June 1571, Landgrave Wilhelm wrote to his brother regarding the report of the visitation committee that had met at Haina in May. Wilhelm commented that 'both hospitals were completely full and overflowing [with people]'. He expressed his desire to know 'who has been accepted to date, when [they arrived] and from where [they came]'.[96] Wilhelm was concerned that the hospitals were housing 'foolish but nonetheless strong young people who were capable to earning their bread through work'. Their presence prevented 'other poor, old and frail people' entering these institutions. The latter were consequently forced 'to suffer poverty and privation [*noth vnnd mangell*]', in spite of the fact that they were the people for whom the hospitals were founded, 'and not the fools [*Narren*]'.[97] He thus advocated a visitation of all of the hospitals to ascertain who had been admitted. Those men and women who were still capable of earning their upkeep should leave the hospitals 'so that other poor people without means [*vnuermoglich*]' could enter.[98] This is an important document in that it is the only official source relating to the institutions that I have found to date that differentiates between

[94] Demandt, Anfänge, p.178.
[95] StAM, Bestand 17I, Nr. 5032. A similar distribution of patients is detailed in StAM Bestand 17I, Nr. 863. It would appear that the documents in question actually relate to 1613 and not, as suggested in the StAM *Findbücher*, 1590.
[96] StAM, Bestand 17I, Nr. 4770.
[97] Ibid.
[98] Ibid.

types of mental illness. It would appear that the Landgrave felt that the 'fools' should not be afforded a place in the hospital as they were theoretically capable of supporting themselves. Presumably, the fact that they were not the 'dangerous insane' also played an important part in this equation.

Wilhelm IV's beliefs regarding the admissions policies of these *Landesspitäler*, with a view to their popularity, are further detailed in a letter dated 21st May, 1575, addressed to both the superintendent of the four hospitals and the governor of Merxhausen. Firstly, no one was to be admitted to the hospitals without the permission of the Landgrave, in the form of a letter signed by his own hand. Secondly, 'young children, upon reaching their eighth year, should leave the hospital'.[99] This related specifically to those youngsters whose parents had died and who had no one to care for them. Provided that they were physically able, these children were to leave the hospital and be put into the service of people who would instill in them a work ethic as well as a Christian code of conduct (*Gottes furcht unndt Christliche Zucht*). As an initial aid, upon their departure, each child was to be given a *Reichsthaler* or a half *gulden*.[100]

It is clear that at this point in time both Landgrave Wilhelm IV and his brother Landgrave Ludwig were also concerned about the abundance of servants (*Gesinde*) present in the hospitals. An over-abundance of patients does not appear to have been their only problem. In a correspondence between the houses dated 27th May 1575, Ludwig expressed his wish that each official in the hospital should submit a list of the number of *Gesinde* that were working for them.[101] This procedure would obviously also enable greater regulation by the Landgraves. Such concerns are echoed in an order written by Landgrave Wilhelm IV to the Chancellor in 1575. The document illustrates the fact that the Landgraves were attentive to the potential for disorder among Haina and Merxhausen's administration. Wilhelm IV commented that the lists of persons both within Haina and Merxhausen revealed that there were *Gesinde* (servants) in the hospitals who served no purpose other than to drain resources. This was

[99] StAM, Bestand 17I, Nr, 5046.
[100] Ibid.
[101] StAM, Bestand 5, Nr. 19106.

particularly true of those individuals who worked in the kitchens and in the fields, as well as those who assisted the shoemaker, the tailor and the master in charge of hunting (*Jegermeister*). The Landgrave wished to see procedures implemented to decrease their number, thereby lifting a burden from the hospitals.[102] Wilhelm IV was clearly concerned about freeloaders within the hospital. He stipulated that 'the over excessive ...number of guests and foreigners [*frembtenn*] should be abolished completely'. The hospitals were founded 'for the poor and not as a guesthouse for the rich...'[103]

One of the obvious consequences of the unexpected popularity of these hospitals was financial. Economic difficulties were directly (although not exclusively) caused by the fact that the hospitals' budgets were stretched to cater for many more people than was ever originally intended. Some of the consequences of this deficit are evident in the correspondence that exists for the early modern period. (This problem remained a more or less constant thorn in the side of the administrators for at least the first two hundred years of the hospitals' existence.) On 22nd March, 1588, *Obervorsteher* Johann Clauer wrote to the Landgraves concerning 'how excessively the number of the poor persons was mounting up, in Hospital Merxhausen in particular...'.[104] Clauer explained that this increase had rendered the hospital unable to buy oxen and provisions. Furthermore, '... there is not enough [money] left in reserve to enable one to provide the poor people, in particular the women in Merxhausen, with clothing and cloth...'.[105] The poor had complained about this situation. Landgrave Ludwig's response largely repeated the ethos that the patients should be held until their recovery, when they are 'able to earn their bread once again'.[106]

Wilhelm IV considered the hospital management partly to blame for the financial problems. In a letter from 6th April 1588, he commented to Ludwig that he found it unbelievable that the hospitals could not survive upon their income. He believed that such problems could largely be rectified through 'good

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[102] StAM, Bestand 17I, Nr. 4753.
[103] Ibid.
[104] StAM, Bestand 17I, Nr. 5032.
[105] Ibid.
[106] Ibid. (27th March, 1588).

housekeeping' and by keeping a careful eye on the employees (*diener*).[107] At this time the St. Elisabeth Hospital in Marburg was being re-built and improved so that it could cater for between forty to fifty poor persons. With a view to this, Landgrave Wilhelm IV had been involved in drawing up a meal plan (*Speise ordnung*) for this foundation. He felt that it might be of benefit for the *Landesspitäler* management to view this plan, in the hope that they might take some of the points on board, and thereby provide more economically for their inmates.[108] (Unfortunately, I have as yet been unable to find a reaction from the hospital management to this suggestion. It is clear, however, that this was not the solution to the problems.)

The recurring problems of overcrowding coupled with overstretched finances are also evident in a later correspondence by Clauer, written in July 1595. He commented that at this point 'both hospitals, Haina and Merxhausen are overflowing [*vbersetzet*] with almost two hundred people more than the quota that was originally ordered'.[109] As a result, nearly all of the revenues collected by the hospital had been used to purchase items necessary for such an unexpected number of people.[110] The situation had clearly not improved in the intervening eight years.

A communication from 31st May 1602 from Landgrave Ludwig the Elder to Landgrave Moritz gives further details of the continuing economic difficulties of the hospital. The message was clear. Haina was losing 2000*fl* per year and must be assisted if they had any hope of avoiding 'turning the wretched out and ruthlessly letting those who qualify for alms (according to the ordinances) loose upon the countryside to wander and decay in poverty, hunger and misery'. It was suggested that the hospitals reduce their population from four hundred and seven (in Haina) and three hundred and eighty (in Merxhausen) to three hundred and two hundred and fifty respectively. Only the most needy would gain entrance.[111]

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[107] Ibid.
[108] Ibid.
[109] StAM, Bestand 5, Nr. 19016.
[110] Ibid. See also Murdhard'sche Bibliothek Kassel, 2o Mss. Hess 429[2, p. 159.
[111] Midelfort, 'Protestant', p. 87. Also StAM, Bestand 40a. Rubr 24, Nr. 98. It must be noted that this document contains none of the references to the population of Merxhausen contained in Midelfort's account.

Similar problems continued throughout the seventeenth-century, as is illustrated in an *Abschied* of June 1613. This report, compiled by representatives of both Hesse-Kassel and Hesse-Darmstadt in conjunction with the *Obervorsteher* Georg Milchling, discusses the 'present' state of these establishments. We learn that the *Landesspitäler* currently held over nine hundred and sixty persons, in the shape of both the poor and the hospital employees (*Diener und Gesinde*). This number had failed to fall, and was if anything increasing. Such burdens on the hospitals prompted those writing the letter 'to think about such means and ways in which the possessions [*haupt gut*] could be ... strengthened'. Suggestions included taxation and a policy whereby 'when an hospital person without children was taken in, and still had goods or property [*gutter*] ...and also a future income, and who had some means, but were without children', should be made to leave their possessions to the hospital, either upon arrival 'or ... after the death of their spouse, if these were still living'. The payments from these 'hospital persons and pensioners [*Pfründen*] would then be used to help the hospitals for the poor.'[112] It would appear that similar arguments were also made in correspondence of 1656. These concerned the 'infirm and in particular nonsensical [*unsinnig*] and raging [both '*furios*' and '*rasend*']' patients who came from the towns and from the Hessian villages that were ruled by nobles.[113]

In spite of the many discussions regarding overcrowding, it remained a constant problem. The *Reskripte* frequently mention that an applicant would be allowed into the hospital 'as soon as a place was free'. As will be seen in the following chapters, this waiting period was to become so customary that the hospitals provided a *Wartegeld* (literally 'waiting money') which served to assist the individual's survival until space was available.[114] In some cases, as is alluded to in the 1728 ordinance, people died before a place was vacated. During particularly overstretched times, a waiting period of a couple of years was not uncommon. Documents relating to the internal workings of the hospital reveal,

[112] StAM, Bestand 17I, Nr. 2336. It must be noted that, although this document is catalogued as 'Abschied wegen der Samthospitäler', it curiously omits any reference to Merxhausen. This is in spite of the fact that it also mentions places other than these hospitals. Also mentioned in Murdhard'sche Bibliothek, Kassel, 2o Mss. Hess.429[2, p. 159.

[113] Murdhard'sche Bibliothek, Kassel, 2o Mss. Hess.429[2, pp. 160 – 161. For information regarding these 'noble villages, see Imhof, Lost, p. 43.

[114] For a brief discussion regarding this topic, see Stöhr, 'Armer'.

therefore, that the reality of the situation did not always match the 'vision' of the hospitals expounded by Philipp the Magnanimous in 1533 and relayed in subsequent ordinances.

IV. External influences and hospital history. Nature and War.

Apart from problems relating to admissions policies and the internal organisation of the hospitals, external influences also had the potential to make a great impact upon the territorial hospitals. It affected not only their ability to cater for the sick poor of the area, but could also significantly increase the numbers of people requiring support. Theoretically self-financing, the hospitals were largely dependent upon their position as landowners – both in terms of their own production and the lands that they leased - to be able to pay for their existence. The hospitals were thus dependent upon external factors for their survival. Phenomena such as droughts, famines and war could have a huge impact upon an institution's ability to provide for itself – this would doubtless have effected both hospital inmates and potential applicants as well. In spite of the importance of these considerations, these themes have been wholly ignored within histories of these institutions. (One exception relates to the Thirty Years War – usually only a couple of sentences are dedicated to this event, normally centring on the destruction and subsequent closure of Gronau hospital.)[115] The confines of space attributable to a thesis mean that I am unable to give too much detail regarding such topics here.[116] Certain aspects, however, deserve mention in order to gain a wider understanding of the position of these institutions within early modern Hessian society.

[115] For more detail regarding the devastation of Gronau, see StAM, Bestand 4h, Paket 1052, 'Kriegsbeschwerden der Niedergrafschaft Katzenelnbogen, besonders des Hospital Gronau 1632'.

i. Nature.

Natural disasters effecting both crops and livestock could impact upon the hospitals, especially in the light of the financial pressures that they already faced as a result of overcrowding. In 1602, for example, the superintendent (*Obervorsteher*) Johann Clauer wrote to Landgrave Moritz, requesting support as a result of the 'loss of the principal livestock [*Hauptviehbestandes*] as a result of a livestock disease [*Viehseuche*]'. Clauer explained that both Haina and Merxhausen had been visited by a 'burdensome and almost pernicious cross to bear [*hauscreutz*]' in the form of 'a dangerous ... disease [affecting] the cattle in both hospitals' Within four weeks 'over seventy of the best livestock had died' in each of the institutions. At the time of reporting '[the] torment [*plage*] had still not ended, so that one must seriously doubt if there will be anything left alive'. Dairy cows (*Melckviehes*) were needed to provide butter and dairy products (*Melckwerck*) for the poor. These institutions had already had to cover the expense both of buying oxen and of various other costs. As a result, Haina and Merxhausen '[are] so totally exhausted of money that I [Clauer] have not even the smallest amount of money [*heller*] in reserve'. He thus felt unable to buy any other replacement livestock, and appealed to the charity of the Landgrave 'to request that Your Princely Grace would, out of princely charity, consider the plight of the poor and would ...reimburse the severe shortages in the hospitals with a princely gift [*Gaben*], so that one can once again buy the necessary livestock... and [so that] the poor will have sufficient maintenance in the coming year.'[117] When one considers that this petition was written in 1602, the same year in which Clauer wrote the aforementioned letter about overcrowding and financial pressures, we can imagine the added effect that such a natural disaster would have. Such events usually lasted for a short period of time, however. As we will now illustrate, wars could potentially have far longer-lasting repercussions.

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[116] This is an area that I plan to expand upon in due course.
[117] StAM, Bestand 17I, Nr. 4785.

ii. War.

Arguably the greatest event to impact upon Haina and Merxhausen – as indeed, upon the whole territory – in the period under consideration here was the Thirty Years War (1618 – 1648). This War had a devastating impact on Hesse as a whole, which lost between thirty and fifty per cent of its entire population during this period.[118] As Arthur Imhof states: 'From the winter of 1622 – 23, when General Tilly's troops took up quarters in Hesse, the people suffered under its chaos almost without interruption right to the end of the war. For them it was, if not a Thirty Years' War, then at least a Twenty-Five Years' War.'[119] Concerning this event, Hans Philippi has asserted that: 'The devastation in states, villages and towns through the often month-long billetings would have been felt to be as terrible as a rampant epidemic or a famine which repeated itself every few years through natural phenomena, and against which one was defenceless'.[120] For the district of Ziegenhain, so near to the border of the warring Hesse-Darmstadt and Hesse-Kassel, the situation reached its peak in the late 1630s and early 1640s. Imhof records how a 1643 survey of this district revealed that in nine of the thirteen localities at least half of the previously inhabited buildings were listed as having been either 'burned down, destroyed or abandoned'. In 1636-37 the village of Loshausen lost twenty-six of its thirty-six dwellings to fire. Similarly, four of the seven buildings in the village of Gungelshausen were destroyed.[121]

It must be noted however that the largest losses are thought to have been due to outbreaks of plague and other epidemic diseases in the 1620s and 1630s – most notably the plague of 1635 - 36.[122] When Tilly's troops returned to the Werra region in 1626, for example, they brought plague and dysentery with them. The

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[118] Robisheaux, 'Peasantries', p. 118. Such statistics can also be found for Franconia, Bavaria, the Rhineland-Palatinate and Württemberg.

[119] Imhof, Lost, p. 18. Imhof is primarily concerned here with the Schwalm region in the district of Ziegenhain.

[120] Regardng this issue of billetting costs in the district [Amt] of Haina, see StAM, Bestand 17I, Nr. 906; Philippi, Hans, 'Machtpolitik unter Landgraf Karl im Hochabsolutismus', in Schultz (hrsg.), Geschichte, p. 107.

[121] Imhof, Lost, p. 19.

[122] Robisheaux, 'Peasantries', p. 118. It is also important to note that, in contrast to the mortality crises of the sixteenth-century, 'hard-hit communities failed to make up the losses quickly'. Studies of the 1630s mortality crises in Hesse reveal unusually high numbers of infant and

potential demographic consequences of this are evidenced by the tombstone of the pastor of Ulfen. It states that in that year some three hundred and forty-nine people had died of the so-called 'red dysentery' (*Rote Ruhr*).[123] The combined effects of both war and plague upon the population of Hesse can be briefly illustrated by the following case study of the Hooss family who owned the Vältes Farm in the village of Leimbach (district of Ziegenhain). Vält (Valentin) Hooss was born in 1626. His father died from the plague in 1635, and his mother, his twelve-year old brother, Johannes, and his sister, Guda, all died the following year. At this point, the only people left on the farm were three orphaned boys aged ten (Vält), five, and four. As a result, the farm was given over to the joint trusteeship both of an uncle from Achenrode (a village close by) and a peasant from a local farm. They were to look after the farm for the next decade until Vält, aged twenty years, took over these duties in 1646. The impact of the War meant however that, in spite of the fact that peace had resumed in 1648, it was not until 1659 that Vält believed the house and farm to be sufficiently restored for him to consider marrying and starting a family of his own.[124]

Compared to many other individuals in Hesse, however, Vält had been fortunate. Further twists of fate could quite easily have rendered him and his brothers suitable for an application to be taken into Haina as orphans. The requisitioning of supplies and the taking up of quarters by both enemy forces and their own troops impacted heavily upon the local population. Horses and oxen were confiscated as draught animals for a variety of transport measures, such as the mobilisation of the artillery. Sheep and cattle were seized for food supplies, as was grain – including the seed grain held for planting the following year. Work in the fields was severely disrupted, resulting in crop failures and the onset of famine. The potential impact of these requisitioning policies is exemplified by the 1640 skirmish at Riebelsdorf (district of Ziegenhain) Here, the imperial army of c. 3,000 cavalry and 1,800 infantry were defeated by the Hessian-French-Weimar allied force of some 2,400 infantry and cavalry. Reports place

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childhood mortality coupled with low rates of marriage and, consequently, of births in the years following these losses. Ibid, p. 118. Also Theibault, German, pp. 166 – 174; Imhof, Lost, p. 20.

[123] Theibault, German, p. 151. For details regarding the '*Rote Ruhr*', see Zedler, Johann Heinrich, Grosses vollständiges Universal Lexicon, Halle und Leipzig, 1732, pp. 1618 – 1637.

[124] Imhof, Lost, p. 13.

losses at c. 1,400 horses and 600 soldiers. Even if, as Imhof points out, we take these figures to be exaggerated, and halve or quarter the totals, replacement horses or draught animals would still have to be found to make up for these losses.[125] Any suitable livestock to be found in the area would have immediately have been seized by the troops, thus affecting still further a local population that was additionally having to cope with the devastation by fire to their villages and towns which had preceded this battle.[126]

iii. Medical provision and the Thirty Years War.

The impact that these skirmishes had upon medical care in the region is an element of the War's history that is all too frequently underplayed. Indeed, the attacks upon one of the four hospitals, Gronau, caused such extensive damage as to force its closure. Reports from the *Landesspitäler* are filled with accounts of pillaging and attacks upon patients. According to a report from Hofheim, a surprise attack on the hospital resulted in enemy soldiers raping 'a chained woman and badly mistreating another aged insane and crippled woman who had been imprisoned in the so-called *Blockhaus* for twenty years'.[127] Similarly, on the 20th May, 1626, J. Friederich Hÿperius, governor of Merxhausen, wrote to the Chancellor and Council in Kassel, the advisers of Landgrave Moritz, regarding the plundering of Merxhausen by Tilly's soldiers. One can sense his frustration, and indeed despair, at the situation in which he found himself. He complained that this was the third time in the past few days that he had written to Kassel regarding 'the deplorable state of the hospital...', and he was still awaiting a reply. It is evident from the letter that this was not the first time that he had corresponded with Kassel. In spite of the fact that the hospitals, as charitable institutions, were supposed to be protected from attacks by either side, the hospital had recently been looted on several occasions. As a result, Hÿperius lamented, 'the poor have nothing left inside [the institution]'. On one occasion, a

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[125] Ibid, pp. 19 – 20.
[126] For more information, see StAM, Bestand 4h, Paket 1052.
[127] A copy of the report is to be found in Anon, Heimatbuch Crumstadt im Ried, Crumstadt, 1979, p. 152f. Quoted in Vanja, Christina, 'Care of the Insane in the Hospitals of Hesse from the

party of soldiers attacked the hospital. When half of their group had finished looting the inside, they swapped over, and the other half came in. They pillaged everything that they could find. 'No corner' was left untouched and they forced open every box (*kisten vndt kasten*) in the place and 'also tried to take everything with them'. Physical force was used. Hyperius complained: 'as tyrants they hit me as well as the poor people, so that I along with the servants [*gesindtlein*] had eventually to run away from them'. Consequently, he 'no longer knows how to support and defend the poor'. Hyperius believed that the continuous plundering meant that it would be better if neither the livestock nor the people were to be seen by the troops. He commented that 'the villages are [also] all empty'. He prayed that 'God the Almighty will save us from this great burden and misery' and implored the authorities to respond to his letter and to offer him advice.[128] The frustration of this individual is quite clear. He felt helpless to defend the hospital – and to an extent, this letter was a justification of his inability to do so.

One should however not merely regard this document as hyperbole designed to defend Hyperius. During the war period, similar stress was also felt by the *Obervorsteher* Johann Clauer. On 18th May, 1632, Clauer wrote to the rulers (*Landesherren*) requesting that he be relieved of his duties as he was finding the economic pressures that the War had caused to be more than he could cope with. They responded on the 23rd May of the same year, imploring him to stay. He obliged. The situation did not improve, however, and on 21st October 1635, Clauer contacted the Landgraves once more with the same request. He presumably met with the same reply as he remained in his duties until 1636.[129]

Haina's geographical location certainly did not help matters. Situated close to the Lower Hessian border, it often came under sudden attack from wandering parties of troops. They robbed the poor of the few supplies of fruit and livestock that they had.[130] A concern for the plight of the poor within the hospitals, and the sense of frustration that there was little that could be done to defend these places,

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16th to the 18th centuries', in Vijselaar, Joost (ed.), Dollhuizen – Madhouses: Chapters from the history of madhouses in Europe 1400 – 1800, Utrecht, 1995, pp. 67 – 77, here p. 70.

[128] StAM, Bestand 17I, Nr. 676.

[129] Friedrich, 'Hohen', p. 148.

[130] StAM, Bestand 17I, Nr. 2303.

as suggested in a correspondence to the government in Marburg from Landgrave Georg, on 1st September 1640. In this the Landgrave explained 'how our *Sambt Hospital* Haina has recently been plundered in a quite deplorable and wretched fashion upon two separate occasions.' The offenders in one instance were the Emperor's troops, and the latter incident involved 'Swedish wandering parties [of soldiers]'. The Landgrave (presumably unable to do anything else) ordered that a special report be made regarding the situation, whereby details would be given as to exactly what had been looted and also as to the effect that such events were having upon the populace.[131]

Of crucial importance is the fact that the effects of the Thirty Years' War clearly did not restrict themselves to the devastation of the territorial hospitals. Reports from Wetter during this period allege that troops had attacked the *'Armen Hospitalhaus'*. The source states that a party *[Parthey]* of 300 men arrived in the town and, among other atrocities, they 'broke into the church, looted the common chests [*Gotteskasten*], took three chalices [*Kelch*] and the money for the poor [*der Armen Opfergeld*], [and] smashed the organ to pieces. [They] stormed the pastor's house [*Pfarrhausen*], hit and stoned the pastor, the women and girls [*Jungfrauen*] who were in the house. [They] raped them, young and old, both those of ten years [of age] and those of seventy years [of age]. [They] stormed the hospital [*Spitalhauß*], threw out the blind and lame, clouted them with axes on the[ir] heads, arms, legs and bodies. [They] pillaged everything. [They] shot dead a young girl [and] forced a blind man, who had been blind for twelve years, to carry a sack of fruit on each shoulder, and as he was not capable of doing this, they hit him twice on the head and stabbed him dead with a sword. A foreign [*fremde*] poor exiled woman [who was] in confinement [*ins Kindbett*]' was also attacked. 'They tore limb from limb another boy who [had] sought refuge in the hospital with axes and hatchets, so that the *posteriora* hung down over his leg and knee.' Apparently 'such tyrannical acts' were carried out in the hospital upon 'the sick, lame, blind [and] poor people, that a Turk would not have done and thought [of] more. [They] also killed other people on the streets and crushed [*gequetschet*] and wounded over two hundred native and foreign persons. [They]

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[131] Ibid.

tortured the poor schoolboys ... and used torture to encourage other to name the people of means. Such [people were] gagged, [so] that the blood flowed out of their noses, mouths, eyes and ears. [They] gave a good hiding to others [and] tied up others with their *pudenda* and dragged them with ropes, the[ir] hands tied behind the[ir] backs ... until foam came out of their mouths'. Reference was made to torturing people until their nails fell away from their fingers. Other people had their 'arm[s] and legs broken in two'.[132]

Even if the reports cited above are exaggerated, it is abundantly clear from many other documents that the people of Hesse suffered greatly during the Thirty Years War. (It must also be remembered that it would have been very simple for the Landgrave to send officials to check on the authenticity of this report.) Correspondence from the village of Rambach (Hesse-Kassel) in 1639 is indicative of this devastation. Their situation was described as follows:
'Today ... the mayor [Herr *Oberschultheiss*] from Wanfried called together the entire community [*Gemeinde*] of Rambach by ringing the bell ... there he saw with a saddened heart how pitifully more than half of the village lay in ashes and found those married people and how with much difficulty (as alas, is clear) they run their households.
Widows who run their own households, but are in utter poverty – 2, one of whom has a pile of poor little ill-bred children.

Men, old and some of whom are infected and burdened with an evil raging disease, so that almost no one can be of any assistance to another – 7.
Widows who stray about with their poor children and breed misery – 6.

Table of animals and what the village saved over winter – cows 2, sheep 0, horses 0, oxen 1, pigs 0, plows [sic] 1.

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[132] Quoted in Justi, Karl Wilhelm & Hartmann, Joh. Melchior (hrsg.), Hessische Denkwuerdigkeiten, Zweiter Theil, Marburg, 1800, pp. 69 – 71. Comparable information can also be found in StAM, Bestand 17I, Nr. 2303. Also quoted in Dr Apel, 'Aus den Tagen des Dreißigjährigen Krieges', Heimat-Schollen. Blätter zur Pflege hessischer Art, Geschichte und Heimatkunst, Sechster Jahrgang, Melsungen, 1926, p. 172. Indeed, some of the report is so similar that it could easily be relating to the same event – further research, outside the scope of this thesis would be necessary before anything could be substantiated. (Were it not the same event, it would raise many questions about the War itself, the nature of the reports, and the role of hyperbole within them.)

A whole wagon with yoke could be put together in an emergency but we would not trust it to last one mile with just half a load.'[133]

In the light of both the evidence cited above, and due to the fact that other districts were making comparable reports, the veracity of these statements becomes less questionable. In many areas of Hesse, the Thirty Years War had a devastating demographic and social impact. In 1592, for example, Wetter had a population of approximately one thousand, one hundred. This population had decreased prior to the War – in 1617, some seven hundred people resided there. Nevertheless the outbreak of fighting contributed to the demise of the formerly prosperous textile industry and the town suffered 'total impoverishment in the course of the seventeenth-century'. It did not experience any real population growth until the twentieth-century.[134]

The end of the War and the onset of peace in 1648 did not signal the end of the problems for many areas in Hesse. As has been shown above, the repercussions often lasted for decades. Surviving documentation from Haina and in particular Merxhausen is illustrative of this process. One of the most immediately obvious changes related to the hospital population. At the end of the Thirty Years War, Haina's population, which had previously stood at around four hundred, had dropped to approximately forty.[135] The length of time that it took for the hospitals to recover their numbers is suggested by a report from 25 November 1668, written by Johann Henrich von Dauber, a member of the Privy Council who had visited Merxhausen. Whereas in the pre-war period, Merxhausen's population had stood at over 300 persons, there were now only forty-five poor people in the hospital – eight of these were men and thirty-seven were women. The food situation had deteriorated greatly and the state of the bedding and clothing can be seen to sum up the crisis. Since the end of the War, the poor had not received one feather for their bedding, and they had so few clothes that 'some [people] lay upon the straw and are unable to ward off the frost'.[136] Many hospital patients were forced to be without shirts when they were washed every

[133] Quoted in Theibault, German, p. 155.
[134] Gräf, 'Small', p. 197.
[135] Apel, 'Tagen', p. 172.

four weeks, as they had no spare clothing to change into. Still others were forced, in the 'hardest winter' to go to Church wearing only a shirt – rather than the bodice (*Mieder*) or jerkin (*Wams*) that they were supposed to wear.[137] A further point of interest in this report concerns problems (once again) with the number of servants within the *Landesspitäler*. We learn that, although Merxhausen at this time only had an inmate population of forty-five poor and infirm persons, it also housed a further fifty-nine people who served the establishment in some way (*Bediente und Dienstgesinde)*, either working in the hospital itself or caring for the livestock (*auf dem Viehhof*). To make matters worse, these employees were frequently accompanied by their wives and children, thus swelling the number from fifty-nine to eighty. It would appear then, that the state hospitals were a popular choice not only for the chronically sick but also for the servants. As Dauber pointed out, this excessiveness was 'doubtless a great drain' on the already depleted resources of Merxhausen.[138]

The Thirty Years War and the dependency of much of the Hessian populace (including the *Landesspitäler*) upon the forces of nature are crucial points to bear in mind when one reads the pauper petitions which will form the major part of this thesis. These events not only affected the immediate locality but, in the case of Haina and Merxhausen, potentially their application process as well. The devastation caused in some areas, such as in Wetter, meant that, whereas people may have previously been able to seek assistance from these urban institutions, this recourse was now lost to them. People who would not normally have been applying for admission now began to do so, and in some towns, such as Wetter, the effects of the War took many decades to be reversed. This is illustrated, for example, in a 1643 petition from the town.[139] The correspondence related to a request by Ludwig Orth, the treasurer (*Rentschreiber*) of Wetter, that one of the town's *Bürger*s be taken into Haina as a result of his mental illness. The individual had lost his sense of reason (*sinloß geworden*). Interestingly, the document stated that it was known that the foundation ordinance of Haina

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[136] Schlieper, 'Ernährung', p. 241.
[137] Ibid. Regarding the improvements in this situation see pp. 240 – 242. For the slightly more favourable situation in Haina see pp. 236 – 239.
[138] Ibid, p. 241.
[139] StAM, Bestand 17e Wetter, Nr. 26.

disallowed the acceptance of anyone from urban areas, stating that '... each and every town in the state of Hesse should provide for their own'.[140] Similarly well known, however, was the fact that, in spite of this proviso, there were 'many examples that various impotent persons from towns' were also being cared for in '*Closter Haina*'. The report continued by explaining that 'the present state of the town of Wetter is unfortunately only too well known'. The town was thus 'without the means to support this person', hence the petition. The *Rentschreiber*'s report offered further detail regarding the situation of Weigandt Arnoldt, the invalid in question. Arnoldt was obviously considered to be a grave danger to the town. In order to prevent him from committing crimes such as murder, he had been confined in a cage for the mad, and was kept watch over. It was feared that, should he be released, he would attack the town with acts of arson and other damages. Indeed, he had already been under suspicion for starting a fire. The town felt itself wholly unable to cope with the situation, hence the petition.

Whether the Thirty Years War can be seen as attributing to a change in the scope of care offered by the *Landesspitäler* is a topic that can not be addressed sufficiently within this thesis, although at face value this would appear to be the case. An analysis of the petitions requires this contextual awareness, especially as it has hitherto been largely glossed over in historical studies of Haina and Merxhausen. While not wishing to diminish in any way the devastation caused by these skirmishes, it must also be borne in mind that it would be possible for the local authorities to use this to buttress petitions to the territorial hospitals that may not otherwise have been accepted. Such a theory must, however, remain pure speculation. Nevertheless, prior to the Thirty Years War, urban areas did apply to have the 'dangerous mad' taken into Haina and Merxhausen as the local authorities felt that their facilities were insufficient to cope with the challenges posed by these individuals. The ravages of war could potentially strengthen such claims and thus effectively force the *Landesspitäler* to extend their admissions net ever wider.

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[140] Ibid.

This chapter has offered a background to the establishment of the Landesspitaler, briefly setting them within the context of the (Hessian) state-sponsored relief systems of the period, and also within the wider remit of Hessian history. The ways in which the original ethos of the *Landesspitäler* was adapted to fit into the realities of their popularity were also considered. Space was also given to a discussion concerning the effects of both internal and external issues (most notably, overcrowding and the Thirty Years War) on the running of the hospital. What, however, did it really mean to be a '*Hospitaliten*'? How could one expect one's life in the hospitals to be? Having considered the hospital in terms of its admissions policies, I will turn in Chapter Two to the question of daily life in Haina and Merxhausen. Upon admission to the institutions, what could one expect (in theory at least) to experience?

CHAPTER 2.
REGULATED SPACES.

Having considered the 'vision' of the hospital in terms of its admission policies, we will now focus upon the institutions themselves. This chapter will detail the physicality of the hospitals in terms of their layout and architectural purpose. Discussion will then turn to aspects of daily administration. We will first look at daily life within the establishments through the perspective of the authorities as evidenced in the hospital conduct regulations. Secondly, we will endeavour to unearth the 'experiences' of the inmates within these institutions. A prime concern lies in the question of feasibility of gleaning such detail about daily realities. Suggestions will be offered as to how such a study can be undertaken. This chapter will thus be devoted to a study of the *Landesspitäler* in both their physical format, and their existence as a location of human activity. How can we describe these places, both in terms of their appearance, and also in terms of the life that went on inside them?

I. Hospital Spaces: The Layout of Haina and Merxhausen

i. Haina.

In the case of Haina, we are fortunate to have been left a detailed sixteenth-century description of the establishment by a Lutheran pastor from Lüthorst in Lower Saxony, Johann Letzener, who published his account in 1588.[1] Of interest to us here is the detail that he offered regarding the buildings themselves and, more importantly, the use to which they were put. Haina was (and still is) famed for its early Gothic church and much space has been devoted to this subject in historical studies to date.[2] Letzener offers a laudatory report regarding the church in the fifth chapter of his publication, claiming that it was the finest monastic

[1] Johannes Letzener (1513 – 1613). Born in Hardegsen in the principality of Göttingen. He studied in Wittenberg and was a pastor in Langenholtensen, near Northeim, in Lüthorst and in Iber. Boucsein et al, 800 Jahre, p. 72.

[2] Perhaps the best example of this focus is Friedrich, Arnd, Kloster Haina, (Die Blauen Bücher), Königstein im Taunus, 1987.

church that he had ever seen – he had already visited almost one hundred other foundations (*Stift*) at this point in time. It is however the fourth chapter of Letzener's text that is of particular importance to this study, for it is here that we are offered a tour around the rest of the hospital.

From the monastic period, Haina was surrounded by 'a double-ringed wall'. The hospital buildings and the living quarters of the officials were found within the inner wall. Around this, within the outer circle, were the inn (*Gasthaus*) and the 'domestic farmyard' (*Oekonomiehof*).[3] The inner section held all of the buildings necessary for running a self-supporting establishment. This included the abbot's house, a hospital, a wash-house (laundry), a brewery, two types of mill (one connected to the bakery, and the other, a *Schneidmühle*), the buildings used for storing fruit and corn, and the houses of the manual workers. The latter constituted shoemakers, tanners, linen weavers, cloth workers, cobblers, blacksmiths, turners, tailors, carpenters and coach-builders. The craftsmen's houses feature in Letzener's 1588 publication and are believed to have existed in the monastic period.[4] In between the outer and the inner walls lay the *Oekonomiehof*. To the west and the south-west lay agricultural buildings, the land that had belonged to the monastery (*Klostergutshof*) and a pond, as well as the farmsteads (*Höfe*) of three fiefs (*Lehensleute*).[5] The hospital walls had three gateways, above which gatehouses (*Torhäuser*) with living quarters had been erected. (For a seventeenth-century representation of Haina, see Figure Two.) Clearly then, Haina was more than merely a hospital. It represented a small rural community, which in many senses can be seen as a small village. Whether this had any bearing on the atmosphere of the establishment from the perspective of the patient is open to conjecture.

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[3] Holthausen, Landeshospital, p. 33.

[4] Wickel, 'Geschichte', p. 197. In comparison to Holthausen, Wickel believes the *Gasthaus* to have been situated within the inner wall.

[5] Between 1565 and 1580, four *Landsiedler* (literally 'settlers' or 'smallholders') came to Haina. They each leased approximately forty hectares of land (*Lehen*). This was paid for in kind, and payment was handed over during the harvest period. Thus for every ten bundles of grain / cereal (*Gebunden Getreide*), four were handed over. Kahm, Otto, 'Geschichte des Dorfes Haina (7). Höfe wurden Privatbesitz', Hessisch-Niedersächisch Allgemeinen (Frankenberger Allgemeine), unter 'Blick zurück und Notizen zur Heimatgeschichte', 11/10/1996.

Figure 2: Hospital Haina, 1646. Taken from the copper etching by Matthäus Merian. Reproduced in Heinemeyer and Pünder (hrsg.), 450 Jahre.

The thirteenth chapter of Letzener's publication discussed the accommodation that was provided for the 'poor, impotent *(gebrechlich)* people' in Haina. He explained that the inmates were divided into six different rooms according to their needs:

'In the first room [*Stube*], called the large or brother room [*Bruderstube*] ... sit ...[those] men [who are] still [able] to move [*gehen*] and to wander [*wandern*] and are capable of doing virtually all types of work. During mealtimes they sit down, four men to a bowl. They have their own special [*sonderliche*] waiter [*Tischdiener*] and attendant [*Auffwarter*] and [they are] read a chapter out of the Bible during mealtimes.

'In the other [the second] room sit old, incapable [*unvermogende*] people, [as well as] the blind and the epileptics.' In comparison to the *Bruderstube*, the men in this room each received their own bowl [*Becker*] from which they ate. They too listened to a chapter from the Bible at mealtimes.

Letzener continued: 'In the third room are those who are so bedridden [*lagerhafftig*] and sick [*kranck*] [that they are] fed [*gespeiset*] by two attendants [*Auffwarters*] ... and that is why this room is called the sick room [*Kranckenstube*].'

The fourth room was called the vault (*Gewolbe*). It housed 'quite a few crazy and lunatic [*Wahn und Mondsüchtige*] persons'. In addition, some mute, deaf, and 'almost clumsy [*fast vngeschickte*]' miserable poor people resided here. Special male attendants were appointed to this room to care for these persons.

Of the fifth room, Letzener writes: '[there are] eighteen massively strong cells under which a stream [the Wohra] flows, so [that] all waste and excrement are removed. And there are three iron ovens placed next to each other, so that the poor raving people [*Rasenden*] who lay locked up in such boxes [*Kasten*] can have their warmth.' Special attendants were appointed to this room. They were commissioned to provide for all of the needs of these inmates and to care for them day and night.

Above these five rooms was a wash-house [*Waschhaus*]. The eight women who were appointed here were to daily wash the shirts, garments [*Kleider*] and bedding of the poor hospital residents, ensuring that they remained clean.[6]

According to Letzener: 'The sixth room is in the leprosarium in which eighteen diseased [*Aussetzige*] men are specially fed. [They] have their own particular [and segregated] place in the church [and] even their own entrance to the church.' They were also provided with their own laundry (the 'wash-house') to which three women were appointed to wash the lepers' clothing.

Letzener continued: 'in addition to these persons are the general servants of the hospital'. The latter obtained their meals from the place in which they worked. The gentlemen [*Herren*] and those persons holding office within the hospital '[eat] in the large guest room [*Gaßtube*] after all other persons have been fed and cared for [*versorget*].'[7]

Citing this report has become a standard part of many of the histories of Haina to date.[8] Scarcely is anything else added to this, unless it is to comment briefly upon later reports (such as that of the Marburg University professor, Karl Wilhelm Justi in 1803) relating to expansions within the hospital.[9] A wide variety of sources contain additional material about the layout of this hospital. Surviving documentation reveals, for example, that a leper's house was built in the early sixteenth century.[10] It was occupied with eighteen persons in 1575 and

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[6] In 1575 there were thirteen women appointed to this task. Demandt, 'Hohen', p. 102.

[7] Letzener, Historische, chapter 13. Italicised spellings are spelt according to Letzener's account. Regarding the layout of Haina, see also Wickel, Carl, Gründung und Beschreibung des Zisterzienser-Klosters Haina in Hessen, sowie einiges Geschichte des Klosters und der Anstalt, Frankenberg, 1929.

[8] See for example, Anon, Neue Europäische Staats- und Reisegeographie, 4, 1754, pp. 751 – 752; Midelfort, 'Protestant', pp. 82 – 83; Vanja, 'Care', p. 70; Idem, 'Madhouses', p. 123; Idem, 'Gender and Mental Diseases in the Early Modern Period: The Hessian Hospitals', in de Goesi, Leonie & Vijeselaar, Jogst (eds.), Proceedings of the 1st European Congress on the History of Psychiatry and Mental Health Care, Utrecht, 1993, pp. 71 – 75, here pp. 71 – 72.

[9] Justi, Karl Wilhelm, Das Hospital zu Haina. Versuch einer Darstellung seiner ehemaligen und gegenwärtigen Beschaffenheit, Marburg, 1803. See also the eighteenth-century travel reports summarised in Vanja, Christina, ' Das Tollenkloster Haina. Ein Hospital in Reisebeschreibungen um 1800', in Matschinegg, Ingrid et al (hrsg.), Von Menschen und ihren Zeichen. Sozialhistorische Untersuchungen zum Spätmittelalter und zur Neuzeit, Bielefeld, 1990, pp. 123 – 136.

[10] Specific dates vary. Demandt suggests that it was first mentioned in the records of 1528. (Demandt, 'Hohen', pp. 99 – 100.) Wickel, however, cites it at the later date of 1556. Wickel,

in his 1588 report, Letzener mentioned eighteen men who were fed separately and who had their own segregated entrance into the church – the inhabitants of the 'sixth room'. The historian Karl Demandt has equated the leprosarium with the *Siechenhaus*, stating that it was situated outside the hospital walls. His evidence is largely based on the fact that lepers were also called *Sondersiechen*, and that the description of the numbers of men residing in this building and the facilities related to them (namely segregation) appear to have been the same for both buildings. Demandt has also linked the special entrance to the church afforded these persons to the so-called 'wood [*holz-*] or *Siechen pforte*'.[11] The hospital ordinance of 1573 however suggests that this may be incorrect. In the section of the document that refers to the duties of the gatekeepers (*Pförtner*), we learn that 'whoever has business in the cattle yard [*Viehhof*] or in the infirmary [*Siechenhaus*] will be let out and in [via the hospital gates] at the correct [preordained] times ... The upper wood- and *Siechen*-gate is therefore only to be opened when wood or other provisions are coming in[to the hospital] ...'[12] Clearly, the exact location of this building remains unknown, but it was certainly not within the inner wall of the hospital.

Throughout the period, Haina expanded in an effort to meet patient demand. Evidence of this includes the sixteenth-century references to the erection of a new *Blockhaus* ('block house') – the 'fifth room' in Letzener's report. This building was situated in the east wing of the monastery, in the former monks' garden. It had a massive substructure (*Unterbau*) with a 'stone floor' and the upper section of this building was constructed in a 'half-timbered' style (*Fachwerkoberstock*). (It remained as part of the hospital until it burnt down in 1880.) Apart from the violent insane (*rasende*), its cages (*Kisten*) were also used to house both hospital inmates who were guilty of misdemeanours and prisoners who came from outside the hospital. The latter illustrates that both Haina and Merxhausen were also administrative centres in their locality and thus held jurisdictional powers over the villages in their district – a role that had previously been afforded to these institutions in the monastic period. Haina's 'prison' thus

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Karl, 'The Haina Provincial Psychiatric Hospital', 1932, p. 432. (Manuscript held in LWV archive.)

[11] Demandt, 'Hohen', p. 99.

pre-dated the hospital. In 1529, for example, Melchior Ringk, a leading Anabaptist had been imprisoned there.[13]

At the time that Justi was writing (1803), the ground floor held some form of lodgings for the attendant, as well as the aforementioned number of 'keeps' (*Behältnisse*) for both the raving mad (*Rasende*) and also for those persons who required secure custody. Two people shared one room that was divided by a thick board wall so as to allow (cramped) individual quarters.[14] Midelfort suggests that these were five feet high and eight feet long – whether these dimensions relate to the whole, or to the 'halved', rooms is unclear. The upper floor held rooms for 'the more reasonable [*vernünftigeren*] ... melancholy patients.'[15]

At the beginning of the eighteenth century, more building work occurred. This time in the guise of the so-called *Magazin*. This structure was built to complement the *Blockhaus* – suggesting that demand was greater than the earlier building could cope with. A new building was also erected for 'calm patients' (*ruhige Hospitaliten*). The so-called *Honoratiorenbau* is also thought to have been built at some point during this century. Located in the west wing of the monastery, it was erected to house 'patients of standing [*Hospitaliten von Stande*]'. Here, as Justi wrote, 'a person will receive care and provisions [*Verpflegung*] appropriate to their background [*Herkommen*]', provided, that is, that they were not suffering from some form of mental illness which rendered them a danger and necessitated their restraint.[16] This building is perhaps the clearest physical indication of the differentiation between the patients which evolved gradually from the end of the sixteenth century, and which was obviously counter to Philipp the Magnanimous' oiginal 'vision'. The *Honoratiorenbau* was demolished at some point between 1850 and 1860.[17]

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[12] German transcription in Ibid, p. 85.
[13] Ibid, p. 101; also Demandt, 'Anfänge', p. 219.
[14] Boucsein et al, 800 Jahre, p. 76; Justi, Hospital, p. 20.
[15] Midelfort, 'Protestant', pp. 83 – 84. Quote taken from Justi, Hospital, p. 20.
[16] Boucsein et al, 800 Jahre, p. 76.
[17] Ibid, p. 76.

We are fortunate to be able to build up such a clear picture of this territorial hospital. Haina retained much of its monastic structure, utilising resources that already existed and building according to demand. The reports of Letzener and Justi offer us snap-shot pictures, frozen in time, of life within the institutions. Undoubtedly important, they have certain drawbacks. It is important to remember that these two works represent an image that is both dependent upon the eye-witness' interpretation and is fixed on one particular moment. Studies to date have failed to sufficiently consider this point, especially regarding the distribution of residents throughout the institution. In order to counter this omission we will briefly look at the lists of hospitals patients which exist for this period to ascertain what the theorectical layout as described above would have meant in reality for the patients.

Lists of hospital residents survive in the yearly account books and the 'kitchen accounts' (*Küchenrechnungen*) of the territorial hospitals. While many of these surveys merely catalogued the patients according to who authorised their acceptance – as will be explained in the next chapter – others divided the patients according to their geographical location within the hospital. The latter cases illuminate the distribution of the patients according to their living quarters at any one given time.

Crucially, these documents also suggest that the reality of the situation could differ from the model offered by Letzener and also perhaps from our preconceptions of how the inmates might be segregated throughout the institution. Details from 1586 regarding the patients in Haina offer a good illustration of this divergence.[18] The lists were divided according to both location and also the person who was responsible for allowing an individual's entrance into the institution. In this instance, the latter differentiated between those persons whose acceptance was granted by Landgrave Wilhelm IV, and those who were instead allocated a place by Landgrave Ludwig. Space was then given to admissions from both the district of Haina and from Merxhausen hospital. (As will be discussed in Chapter Three, these categories did not remain constant

[18] A copy of the 1586 list is printed in Demandt, 'Hohen', pp. 114 – 132.

throughout the entire period under consideration here.) We learn that in 1586 sixty-five 'poor, old persons without means [*unvermöglich*]' resided in the large *Brüderstube*. Permission for the entrance of thirty-two of these *Hospitalpersonen* came from Landgrave Wilhelm, and twenty-eight from Landgrave Ludwig. Four of the remaining five persons came from the district of Haina. All four were from the neighbouring village of Löhlbach, and all were over the age of sixty. At least one of these men had previously worked for the hospital in some capacity, and at least two of the men were specified as being accepted upon the condition that they provide services for the hospital – in this case, those of thresher and a bricklayer. (At this point, it is sufficient to merely note this aspect of hospital life – patient 'labour' -within the *Landesspitäler*. This topic will receive attention in Chapter Six.) The one candidate to arrive from Merxhausen hospital was Johannes Lummel. He was 'a poor boy, aged nineteen years'. He had been brought up in Merxhausen, but was transferred to Haina, presumably because of his age (theoretically this should have happened much earlier), and because his physical or mental condition prevented him from being able to cope in the outside world. Unfortunately no further details were noted.

Contrary to Letzener's description, it would appear that a large number of the patients residing in the large *Bruderstube* might have been unable to move around with the ease that the 1588 publication suggested. Many of these persons were described as lame and aged (*betagt*). These ailments were found in the second room also, another divergence from the pastor's representation. It appears that only a few of these *Hospitaliten* were capable of work - only thirteen out of a total of thirty-five persons were specifically listed as being in employment. A total of sixty-nine people were housed in the second room, the *Blindenstube* – forty-eight of these persons had their applications supported by Landgrave Wilhelm, and the remaining twenty-one by Landgrave Ludwig. Apart from the additional presence of the blind and the epileptic, in 1586 there was no other noticeable difference between the patients in the *Bruderstube* and the *Blindenstube*. Similarly, the discernible differences between the chronic conditions suffered by those inmates in the first room and the *Krankenstube* - which in 1586 held eighteen persons - do not appear to have been as great as one would imagine. In comparison to the pastor's account, the sixteenth-century

listing amalgamates the details of those persons residing in the 'vault' and the prison. The thirty men within these buildings were deemed to be minors (*unmündige*) and insane (*wahnsinnige*) poor persons. While these rooms seem to hold a slightly smaller proportion of elderly persons than other rooms, it would be a misnomer to consider it an overwhelmingly 'young' room. Ages were mixed. The population certainly did not include any of the (thirty-eight) children who were also mentioned in the accounts, but who were, interestingly, not allocated a specific room in the list. Indeed, only two of those persons residing in the 'vault' or the prison were what could strictly be classified as 'underage' (*unvermündig*). Both of these individuals were ten years of age, and both are listed as 'mute'. (The second youngest age was sixteen.) We must thus assume that it was the presence of the latter which necessitated the age reference, and that the majority of persons were instead either *'wahnsinnige'* or had committed some form of misdemeanour. Twenty-six diseased persons [*Aussätizge*] and an additional three women are documented and were presumably confined to the *Siechenhaus*. All of the latter were employed as washerwomen for these afflicted men – two of the three were the wives of leprosarium patients.[19]

A second section of the hospital population, those patients who were considered capable of work, were not allocated space within Letzener's room plan. This aspect of hospital life has received only infrequent mention within historical studies to date. It also sheds light upon the uses to which the other hospital buildings were put. (It is not inconceivable that these individuals also resided in these buildings – although, for some of the professions, this goes against the information cited above relating to the gatekeeper allowing the patients to go out to work.) The 1586 list makes it clear that many of the poor inmates also performed a variety of tasks throughout the hospital. Thus they appeared in this document as working as wool- and linen-weavers (fourteen persons), as tailors (twelve persons) and within the professions of shoemaking and tannery. Inmates were also accepted to help with the baking and the brewing. They were also employed in the mill, in the kitchens and in other capacities as manual labourers

[19] Unfortunately, few of these early petitions for *Aussätzige* survive. Where they are extant, they offer little additional evidence. See for example, LWV, Bestand 13, Reskripte, 1578 (Paul Hippen von Rodenbach).

(eighteen patients). A further thirteen men undertook some form of cow-herding (*Viehhütern und –wärtern*), and five of the poor worked in the hospital's iron foundry at Fischbach. Twenty-two women were also included in the hospital population. Their tasks included washing the clothes of the poor and spinning thread and wool (*Garn, Wolle und Zwirn spinnen*). Six of the poor were listed as receiving the same food as the servants – a matter that will be discussed in Chapter Three. There were also forty-eight 'servants' (*Dienern und Hausegesinde*). Interestingly, this included a 'mill doctor' (*Mühlenarzt*) and his wife, although I have been unable to discover any other information about this employee.

Studies of further patient lists from Haina offer us additional insights into the layout of the institution. While an in-depth account of these subtle changes is outside the confines of this study, these records are useful for allowing us to see how the hospitals adapted physically to external events such as the Thirty Years War. For example, the list of Haina patients from 1630 divided the inmates into the *Großen Stuben* (a total of seventy-two persons), the *Blindenstube* (seventy-one persons), the 'vault [*Gewölbe*]' (twelve persons), the *Kranckenstube* (eight persons) and the prison (sixteen persons). Additional people were listed under the following divisions: the first being those individually listed (*Inn Eintzeln Gemachen*) (twenty-two persons, probably employees). The lists frequently included wives as well. The second section related to the 'upper wash-house'. This housed seven persons, at least six of whom were women, who were employed to launder the inmate's clothing. At least one of these women was 'old' (Cristina von Huttenrodt) and one was lame (Catarein [sic] von Almerode). In addition there were a further four persons – including one child – in the 'lower wash-house'. It would appear that the child was related to one of the women housed there – for whatever reasons, the unnamed 'child' was attached on the list to one of the inhabitants. A separate section was given over to 'children in the wash house'. Given that the 'lower wash house' already mentioned a child in its lists, it seems likely that these children were attached to the 'upper wash house'. All of the nine children were described as 'boys'. One was additionally listed as being blind (Tobias Kneib from Obernholtzhaußen), and the rest were described

as 'small' (*klein*) children. Presumably the washerwomen were also responsible for caring for these minors.

It is immediately obvious that, in name at least, some of these rooms have been given titles and references which differ from those in Letzener's study. This is obviously in part related to the changes that occurred in the intervening years – including, not least, the physical expansion of the hospital in terms of its buildings. This is an important issue that has been overlooked in previous studies. Perhaps the clearest indication of these developments can be found in a 1714 document relating to the distribution of epileptics within Haina. These persons were not, as Letzener would have us believe, confined to the 'second room' – indeed this is not mentioned. Thirty men are listed – ten of whom reside in the sick room under the care of one attendant, Peter Möller. Three are present in the so-called *Capittal* (sic). (The exact location of this room is unclear.) One is in the lower *Magazin*. A total of ten people are in the *Blockhaus*, eight of whom are in the upper section. The final six sufferers are listed as living in the building next to the *Blockhaus*.[20] One attendant is assigned to each of these designated areas. (As will be shown in Chapter Three, the *Aufwärter* were usually assisted by their wives, thus doubling the number of overseers in each ward.)

Change is of course inevitable, but how are we to account for the apparent (and previously uncommented upon) discrepancies between Letzener's account and the sixteenth-century patient lists? Such divergences may be explained in two ways. Firstly, the pastor's publication is obviously a subjective document, based on his visit to Haina. His evaluation of the segregation of the illnesses may well have been founded upon his observation and appraisal of the situation. (We do not know whether or not he corresponded with any of the hospital administrators regarding their policy for such matters.) Secondly, this case study reveals the shortfalls of relying solely upon such patient lists and architectural descriptions - a matter that will afford discussion in due course. The brevity of the information offered prevents us from gleaning a full picture of the reality of hospital life.

[20] StAM, Bestand 17I, Nr. 2195.

One of the most important realisations to arise from this study relates to our comprehension of the terminology involved. Is our understanding of specific words the same as that of the early modern person? If the answer is 'no', to what degree does divergence exist? The purpose of the leprosarium and its connection to the *Siechenhauß* is a case in point. The 1630 accounts from Haina are illustrative of this problem. Literally translated, '*Siechenhauß*' means 'sick house' or 'infirmary'. Demandt has connected this to the leprosarium, suggesting that 'diseased' persons were catered for here. It is clear however, from consulting the details of those resident in the *Siechenhauß*, that in 1630 only two out of the nineteen persons listed were described as '*siech*', meaning 'ailing' or 'infirm'. Quite how this condition differed from those suffered by the rest of the building population is unclear. How for instance did the '*Siechen*' compare to the 'frail' or the 'impotent' (*gebrechlich*)? The majority of the residents suffered from a range of physical conditions such as lameness, frailty and old age. Some were specifically listed as working within the institution in 'public' employment such as caring for the horses and cows. Given that an infectious disease would spread fairly rapidly, it is unlikely that these persons would have been suffering from such conditions. On the face of it, this list proves that the *Siechenhauß* in this period was not just for *Sondersiechen*, as had been the case when it was clearly a leprosarium, but rather the sick in general. How do we explain this occurrence? From the dating of the document, one might assume that it would be connected to the Thirty Years War, and that this was an emergency measure. A closer reading of the text as a whole suggests however that this is unlikely to have been the case. After all, the hospital was still able to cater for some two hundred and sixty-six people, and all of the other customary rooms listed by Letzener were in use. Overcrowding might be another explanation, but this too is unlikely.

It would appear that the hospital administrators utilised the *Siechenhaus* according to demand. This building cannot be connected to the location recorded in thirteenth-century documentation as the *Infirmarium*.[21] Neither can we fully

[21] Regarding *Klosterspitäler*, see Knefelkamp, Ulrich, Das Gesundheits- und Fürsorgewesen der Stadt Freiburg im Breisgau im Mittelalter, Freiburg m Breisgau, 1981, pp. 49 – 53; Vanja, Christina, 'Vom Gottesdienst zur Fürsorge – Die mittelalterlichen Hospitäler', in Seibt, Ferdinand et al (hrsg., Vergessene Zeiten. Mittelalter im Ruhrgebiet. Katalog zur Ausstellung im

equate it with a leprosarium in its most specific sense. If the assumption that this building lay outside the hospital walls is correct, then it is perhaps most likely that this building was utilised for the infectious cases as they appeared. At other times it was as is name implies, an infirmary. Quite how – and indeed if – the conditions suffered by these 'infirm' differed from the rest of the population is unclear As Anne-Marie Kinzelbach has illustrated in her study of medical provision in the Imperial cities of Ulm and Überlingen, we must constantly be mindful of the fluidity of terminology that existed in the early modern period. We cannot, for instance, be sure that at a given point in time a particular institution or building only catered for and contained the persons that its name suggests. Thus at various points throughout the history of the *Siechenhaüser* in both Ulm and Überlingen, these institutions clearly held persons other than the lepers that Kinzelbach suggests they were intended for.[22] This also seems to be true of the *Siechenhaus* in Haina.

Similar caution should also be taken with the other rooms in the hospital. A 1706 patient list divided the inmates into four locations within the hospital: the *Capittell* [sic], the *Blockhauß*, the *Kranckenstube*, and, finally, the *Großenstube*. It is quickly apparent, however, that the confined mad were not merely in the *Blockhaus*. One hundred and sixty-six persons were included in the list. Forty-one of these were allocated to the *Krankenstube* and thirty-one to the *Großenstube*. The *Capittell* and the *Blockhauß* respectively held forty-six and forty-eight individuals. All of these areas contained a mixture of patients. The *Krankenstube* held two men (Conrad Klein and Jonas Wentzell) who were both described as 'lying in chains'. The same treatment was listed for Johann Claus Ferne and Henrich Keÿser (*Capittell*), and for Johannes Gerbach (*Großenstube*).

Ruhrlandmuseum Essen, 26. September 1990 bis 6. Januar, 1991, Band 2, c.1991,pp. 192 – 196, here pp. 192 – 193.

[22] Kinzelbach, Anne-Marie, Gesundbleiben, Krankwerden, Armsein in der frühneuzeitlichen Gesellschaft. Gesunde und Kranke in den Reichstädten Überlingen und Ulm, 1500 – 1700, Stuttgart, 1995, pp. 355 – 363. Kinzelbach defines *'Sieche'* thus: *'Der Ausdruck 'Sieche' wurde in Überlingen und Ulm vor allem im späten Mittelalter und während der ersten Hälfte des 16. Jahrhunders sowohl als allgemeine Bezeichung für Kranke sowohl auch als Spezialterminus für Leprosse benutzt (den Ausdruck 'Sondersieche' allmählich ablösend). Im 17. Jahrhundert scheint er ausschließlich für Leprose gebraucht worden zu sein.'* Compare to the comments of L. Müller: *'Man unterscheidet deshalb Siechenhäuser für Kranke im allgemeinen und Sondersiechenhäuser oder Leprosorien für Aussätzige'*. (Idem, Marburger Wohltätigkeitsanstalten und Stiftungen, Marburg, 1911, p. 3.)

The latter was described as an '*epilepticus*'. No comment was entered regarding his mental state. Only two persons in the *Blockhaus* were described as being chained – Johannes Hase and George Halbey. No accompanying illness was listed.

Two further points are of note relating to this 1706 account. Firstly, eleven people were recorded as '*absens*'. Two of these (Henrich Muller and Henrich George) were '*epilepticus*' and one (Caspar Daum) were imbecilic (*blöden Verstands*). A further four were described as old and another two as *miserable*. One of these persons, Peter Herling, was listed as old and as having complained about the hospital provisions. The reason for the absence of these eleven men is unclear. Their entrance in the accounts suggests however that the places have been left open for them.

Secondly, some people were clearly registered as 'cured', and yet their presence within the hospital appears unquestioned – although, as will be discussed in due course, this was clearly against the ordinance stipulations. Wilhelm Clemens (*Blockhauß*) was listed as acting as a messenger (*geht Bottenweiß*) and had been 'liberated from melancholy'. George Seibert (*Großenstube*) was described in the following manner: 'was an epileptic but has now been free [of this affliction] for one year'. The comment relating to Nicholaus Feige was even clearer: 'healthy and can work'. At present we do not know how they had managed to remain in the hospital. Particularly when the entry relating to Siebert Schefer (*Blockhaus*) stated 'is cured of his injury and wishes to search for his upkeep [outside the hospital]'.[23] Are we to conclude therefore that it was the patients who decided when they left the hospital after their health was restored? It may well be that the authorities were not as strict about such procedures as one would expect. Whatever the reason, their presence was clearly contrary to hospital orders.

Examples from other areas of practice within the territorial hospital remind us once more that we should not merely rely upon a name or indeed a regulation to provide the whole picture. Perhaps the best illustration of this relates to the

[23] StAM, Bestand 17I, Nr. 2195.

poverty of the inmates. As will become increasingly clear in Chapter Three, the *Armenspitäler* (literally 'poor hospitals') of Haina and Merxhausen, as Landgrave Philipp sometimes referred to them, did not always contain only *Armen* (the poor). The meaning of terminology thus altered to accommodate the situation at a particular time. It did not necessarily remain constant – nor indeed logical to our modern way of thinking.

ii. Merxhausen.

Unfortunately no surviving comparative report describing the hospital layout exists for Merxhausen as it does for Haina. The relative lack of historiographical interest in Merxhausen as compared to Haina is illustrated by the fact that studies to date have failed to touch upon this aspect of the institution's make-up. Where references do exist, they serve to set the hospital within its geographical location in Hesse.[24] Descriptions of the actual buildings are rare.[25] (Visual imagery is similarly scarce. Figure Three shows one of the few – arguably the only - seventeenth-century depiction of Merxhausen.)

As with additional documentation for Haina, it is possible to piece together an image of Merxhausen, utilising information gleaned largely from the yearly accounts and inventories. Space restrictions necessitate that we curtail our discussion to a brief description of the hospital layout. As with Haina's source

[24] This usually stresses its proximity to the Ems River, and the fact that Merxhausen is located in 'a deep valley gorge'. See, for example, Schenk, Geschichte, p. 14; Landau, Das Kurfurstenthum Hessen, Darmstadt, 1865, p. 321; Amelung, Heinrich, 'Bericht über das Landeshospital Haina in Kurhessen', in Correspondenz-Blatt der deutschen Gesellschaft für Psychiatrie und gerichtliche Psychologie, 1854, Neuwied. 1 Jahrgang, p. 27.

[25] For an exception to this rule, see the brief comments in Gannsanje, G. et al (bearb.), 'Merxhausen', in Winter, Wilhelm, Bau= und Kunsts Denkmäler im Reg- Bezirk Kassel, Band 1, Kreis Wolfhagen, 1937, pp. 102 – 118.

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Figure 3: Hospital Merxhausen, 1646. Taken from the copper etching by Matthäus Merian. Reproduced in Heinemeyer & Pünder (hrsg.), 450 Jahre

material, we can assess how the inmates were divided up into a variety of rooms – although we may not be able to pinpoint exactly where these lay. For instance, the patient list from 15th July 1575 named three hundred and seventy-five persons. Eighty-six of these were males, while two hundred and seventy nine were female. Amongst the women, we learn that they were divided throughout the hospital in the following fashion. Twenty-one 'sisters' were in the *Siechenhaus*, and the same number were in the 'small sick room' (*kleine Krankenstube*). Forty-nine inmates were in the 'large sick room' (*große Krankenstube*). A further six persons were confined to the prison (*Gefängnis*), where they were attended by six *Aufwärterinnen.* The fact that these attendants were female is particularly interesting given the later eighteenth stipulation that it was not advisable to have only female attendants (*Aufwärterinnen*) as they had insufficient 'strength' and 'authority' (*Aufsicht*) to deal with the violent mad (*Rasende*). [26]

In 1575, the majority of inmates (one hundred and sixty-one persons) were housed in the 'large hospital room' (*große Spital stube*). In addition to this were a further nine poor women who worked on the hospital land (*auf dem Hofe*). Two other women were also named: the sister of Dr. Moritz Thauer (the personal physician of Landgrave Wilhelm IV) and the wife of Johannes Sachse, the pastor of Dörnberg. The latter was described in 1575 as 'weak in the head'. Karl Demandt states that these two women were 'obviously given better treatment'.[27] As will be discussed in due course, it would appear that differentiation between the patients quickly emerged within the territorial hospitals. Such distinctions were evidently contrary to the original 'vision' of Philipp the Magnanimous.

The distribution of *Hospitaliten* remained fairly similar throughout most of the period under consideration here. In 1626, for example, we know that there were thirty-one 'sisters' - as the female patients were called - in the large hospital room (*großen Spital stueben*). In addition seventeen persons lived in the

[26] The quote is from the *Vogt* of Merxhausen (1793). Cited in Vanja, Christina, 'Amtsfrauen in Hospitälern und der Frühen Neuzeit', in Lundt, Bea (hrsg.), Vergessene Frauen an der Ruhr. Von Herrscherinnen und Hörigen. Hausfrauen und Hexen 800 – 1800, Köln, Weimar & Wien, 1992, pp 195 – 209, here p. 202.
[27] Demandt, 'Hohen', p. 103, fn 233.

Weberhaus, twenty-nine in the large room for the sick (*großen kranckenstueben*) and twenty-one in the small room for the sick (*kleinen kranken stueben*). A further eleven sisters were in prison (*in gefangnus*), fifteen were in the *Siechenhaus*, and thirty-three were listed as being *vff dem Hoff*.[28] The latter distinction seems to imply that either these individuals, or at the very least their spouses, worked within the hospital. Thus in a 1715 list, three women were admitted *Vff dem Hoff*. Two of them, Anna Scherpmannin and Magdalena Meÿin, are listed as *Armen Diener* in the *Weberhaus*. The third, Maria, the wife of (the attendant) Martin Ritter, was described as being an attendant of the sick (*Krankendienerin*).[29] Comparatively, in the 1660 *Jahrrechnung* eleven out of the forty-four persons in the hospital were described as living *Vff dem Hoff* – complaints relating to this matter have already been discussed in the preceding chapter. The spouses of all except one of these women were employed at Merxhausen, in a variety of operations ranging from shepherd to reader or forester.[30]

A list of 'poor sisters' in Merxhausen in 1669 offers an interesting perspective of the hospital after the Thirty Years War. Only thirty-four 'sisters' were mentioned. They resided within two main areas – in the *Weberhaus* or in the *Kranckenstube*. Only six persons were to be found in the latter building. Of the rest, in the *Weberhaus*, a further distinction was noted. Six of these 'sisters' were registered as 'lying in chains [*Ketten*]'. Of the remaining twenty-one women, marginal notes that have been added to the list offer us a more detailed picture of the situation. A certain 'Christina from Bahlhorn [sic]' was noted as 'lying on the bed'. Moreover, it is recorded that she 'needs [unspecified] medication'. (Further comment relating to this will appear in the wider discussion regarding medical care in Haina and Merxhausen, as featured below.) 'Elsa from Homburck [sic]' was listed as 'an old, sick woman [who is lying] upon the bed'. It would appear that 'Catharina from Heÿna' looked after her (and potentially the other elderly sisters as well). She was noted as 'attending to the old woman [*vffwartet vff die alte fraw*]' – her charge was presumably Elsa, as her name immediately preceded

[28] StAM, Bestand 229I Landeshospital Merxhausen, (henceforth referred to as Bestand 229I) Jahresrechnungen, 1626.
[29] StAM, Bestand 17I, Nr. 2195.

Catharina's in the list. One of the patients, 'little Gelchen (*Klein Gelchen*)' was described as being unable to mobilise herself with the use of her legs. It would appear that she was forced to crawl on the floor (*gantz gekruebt zur erden)*. A final comment related to 'Christina, the daughter (*Tochterlein*) of Hl. Oldendorpÿ'. She was now living in the governor's house.[31] Clearly this was another example of an inmate receiving preferential treatment. The 1669 situation represented an improvement on that of 1660 when, with the exception of the aforementioned labouring women (*Vff dem Hoff*), the rest of the sisters lived in the *Weberhaus.*[32]

A furniture inventory from Merxhausen in 1681 provides a good indication of the rooms within the hospital – or at least those that were furnished (in the widest sense of the term). In addition to the large amount of space given to persons working within the institution – ranging from the superintendent and the governor to the cattle-shed and the stables – mention is also made of accommodation for the sisters. The *Krankenhauß* for example, also had some bedrooms and a small room. Also listed were the largest hospital room, the *Weberhauß* and the *Siechenhauß*. The latter was presumably outside the central hospital area, as in Haina. It was described as being in an area referred to as '*uf der bleichen*'. Similarly, as in Haina, this establishment also had its own schoolroom, suggesting that some form of tuition was offered in this hospital as well.[33] Unsurprisingly, as is the case with Haina, the Merxhausen hospital had largely structured itself around its existing monastic architectural template and had adapted this to suit its needs. Slightly more divergence might however be evident at Merxhausen due to the much greater devastation caused by the Thirty Years War in this institution than at Haina. This is a topic that I plan to expand upon at a later date.

Sources relating to the layout of the *Landesspitäler* allow us to take a 'virtual tour' of these establishments and to form a picture of the 'life' therein. Provided that we bear in mind the cautions mentioned above, these documents can be

[30] StAM, Bestand 229I, Jahresrechnungen, 1630.
[31] StAM, Bestand 17I, Nr. 2195.
[32] StAM, Bestand 229I, Jahresrechnungen, 1660.

particularly helpful tools to help us reconstruct the past. Additional archive material, such as regulations and other forms of correspondence serve to deepen this perspective. It is to such considerations that we will now turn.

II. Daily Life in Haina and Merxhausen.

The earliest hospital ordinances made it clear that the ideal lifestyle within these institutions was envisaged by the Landgrave and the superintendent to be one that was 'strictly Christian in character'.[34] As has already been shown in the preceding chapter, the hospital's clientele were clearly envisaged to be the 'worthy poor', those who were 'worthy of alms [*Almosenfähig*]'. To meet such credentials, one had to have led a Christian lifestyle appropriate to such charitable benevolence. Such standards were to continue within the hospital, as the opening sentence of this section of the rules reads. The regulations were intended so that: 'those poor [persons] cared for in the hospitals [*Spitäler*] [should] live according to Christian rules and an honourable way of life...'[35]

The day was strictly regulated and was clearly reminiscent of monastic ideals. Those who were capable were expected to awaken at the sound of a bell. They had half an hour in which to wash and dress and were to ensure that they kept themselves clean, 'so that they did not live as pigs in a pig pen'. This was not just the will of the hospital officials - and by extension, the state - but also of God.[36] After this time, signalled once again by the sound of the bell, the brethren

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[33] StAM, Bestand 229I, B17, Paket 1.

[34] Midelfort, 'Protestant', p. 79. Midelfort also summarises this section of the ordinance (pp. 79 – 80). Indeed, references, of varying detail, to this hospital ordinance abound within previous historical studies. In order to provide a context for understanding the petitions, it is necessary to reconsider these regulations here. See also, among others the work of Vanja and Holthausen. Perhaps the best in-depth studies to date regarding the early formation of Haina (and to a far lesser extent Merxhausen) can be found in Midelfort, 'Protestant', and especially in Demandt, 'Anfänge' and Idem, 'Hohen'. For the purposes of this discussion, the document used is the *Grundstatut* as transcribed in Demandt, 'Hohen', pp. 48 – 57. (Also cited, in part in Franz, G., Urkundliche, pp. 189 – 197.)

[35] Demandt, 'Hohen', p. 49.

[36] A Biblical quotation is then cited. Midelfort ('Protestant', p. 79) suggests that it is found in Romans 13, verse 13. I have been unable to trace the original source referred to in that in Midelfort's publication, but in the document (cited in Demandt) that this chapter is primarily utilising, the reference comes instead from The Letter of Paul to the Colossians (*Kolosser*). It

were to meet. They would either collect together 'in the church [at 5am] during the summer or in the [heated] rooms [at 7am] during the winter, where one should instruct them to thank God for watching over them in the night'.[37] This was to be followed with a short lesson from the Catechism, and prayers 'for the prince, for peace, for the governor (*Vorsteher*) of the hospital, and for all of the needs of Christendom. For as Christ said: Seek ye first the kingdom of God.'[38] So as not to overstretch the memory of the elderly, this service was not to run for longer than half an hour.

The brethren now turned, according to their own capabilities, to a variety of forms of light work. Specific detail regarding this aspect of hospital life will be given below, and in Chapter Six. It is worth noting (as a point of contrast for later discussion) that Midelfort cites as examples of such employment in Haina 'making baskets or brooms, tidying up, working in the garden, splitting wood, [and] watering the meadow'. By contrast, the women in Merxhausen would be involved in 'sewing, knitting, crocheting, and other sorts of 'women's work''.[39] Similarly, it must be realised that the territorial hospitals were not alone in this practice. Far from evidencing a shift to the confined 'workhouse' ethic that Foucault propounds, this policy followed in the footsteps of a wide variety of other hospitals.[40] Examples can be found from at least the fourteenth century in a variety of places, including Munich, Würzburg, Inglostadt, and Bamberg.[41] Within the *Landesspitäler*, the purpose of such tasks was not a profit-making exercise, nor 'for the great usefulness of such work but so as not through idleness to give the Devil room'.[42] During the designated periods of work, the pastor would visit those residents who were unable (through physical or mental

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must constantly be borne in mind that there are frequently slight differences between the copies of the various hospital orders.

[37] Regarding the notion that the bell tower was one of the defining features of a medieval hospital, see Knefelkamp, Ulrich, 'Das städtische Spital als Ort der Frömmigkeit', in Idem (hrsg.), Stadt und Frömmigkeit, Colloquium zum 70. Geburtstag von Gerd Zimmermann (11. – 13. November 1994 in Bamberg), Bamberg, 1995, pp. 53 – 77, here p. 56.

[38] Demandt, 'Hohen', p. 49.

[39] Midelfort, 'Protestant', pp. 79 & 82.

[40] Foucault, Discipline. Compare to Eisenach, Ulrich, Zuchthäuser, Armenanstalten und Waisenhäuser in Nassau. Fürsorgewesen und Arbeitserziehung vom 17. bis zum Beginn des 19. Jahrhunderts, Wiesbaden, 1994.

[41] Schrott, Ludwig, Das Heiliggeistspital in Bayern, München, 1962, p. 237; Knefelkamp, 'Städtische', p. 70; Vögel, Hubert, Die Urkunden des Heiliggeistspitals in München, 1250 – 1500, München, 1960.

incapacity) to attend the morning prayers (and were also unable to work). He would repeat his earlier service, 'in order that these people too as they leave this world may be prepared and sent to their Father. And it would be good if every day the sick could hear some words of comfort, if short and full of consolation, so that they might be cheerful and undismayed by death and eager for eternal life'.[43]

Within the *Landesspitäler*, mealtimes were also strictly regulated. The 1573 ordinance clearly stipulated that 'these two things are ... the most important [*die dringlichsten*] in the hospital: (1) that one supervise the kitchen to assure that everything is clean, useful, well cooked, and faithfully given to the poor [brethren], and (2) that the poor are visited daily that they do not remain unconsoled.'[44] Prior to the meal at 9am, the residents were 'to wash and then to sit themselves down and pray. During the meal, God's Word is to be read aloud, from the New Testament in the mornings (but not from the Book of Revelation) and from the Catechism in the evenings.'[45] The purpose of this exercise was to instruct newcomers, who arrived throughout the year. Following this meal and a prayer of thanks, the residents had one hour free in which to see to personal matters, make their beds and tidy their rooms. More work would follow until a break for lunch (*Vespertrunck*) at 1pm – usually beer, bread and cheese. Each person would then continue to work to their own ability until the evening meal at 4pm or 5pm – 'for all work should only serve to protect against the Devil [*Arges zu verhüten*].'[46] Following the meal and a further prayer of thanks, all persons were to rest before going to bed at a set time, so that they would awaken the next morning, fully prepared for the day ahead.[47]

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[42] Translation from Midelfort, 'Protestant', p. 79.
[43] Ibid, pp. 79 – 80. Original transcribed in Demandt, 'Hohe' p. 50. For a discussion of the role of the Lutheran pastor during an individual's preparation for death, the importance of beliefs in the Devil, and the Catholic remnants that existed within such activities, see Karant-Nunn, Susan C., Reformation of ritual An interpretation of early modern Germany, London & New York, 1997, pp. 169 - 170.
[44] Translation from Midelfort, 'Protestant', p. 80; Original transcribed in Demandt, 'Hohen' p. 50.
[45] German transcription in Demandt, 'Hohen' p. 50.
[46] Ibid, p. 50.
[47] For an in-depth study of food consumption in the hospitals, see Schlieper, 'Ernährung'. To gain a comparative perspective, see also Idem, 'Nahrungsmittel und Ernährung in der Landgrafschaft Hessen-Kassel, 1650 – 1730', in ZHG, 81, 1971, pp. 65 – 88, Idem, 'Nahrungsmittel und Ernährung im alten Kassel (1585 – 1632), ZHG, 79, 1968, pp. 55 – 76.

The Lord's Supper was observed monthly, although the rules were flexible enough to permit those who felt a special need to be allowed to partake in this sacrament at a time in between these regular celebrations. In order to be allowed to participate in this service, an individual would have to go to the pastor on the previous Sunday evening and to give an account of his faith, life, lifestyle and sins. Repetition of sections of the catechism was also necessary. Were it not possible to cover this ground within a day, the process could take the entire week, for 'whoever does not know his ten commandments, creed, Lord's Prayer, etc., should not be admitted to the sacrament until he learns them, for they are established for Christians. And if he doesn't know about Christ, how can he be called a Christian or be one?'[48] Absolution was viewed as a means to strengthen those with weak consciences. The hard-hearted were instructed in God's law. Having been made knowledgeable of their sins, they would become capable of receiving the Gospel. Those brethren who could sing were to be taught psalms and prayers from the Wittenberg Order. The latter might then be sung in church and before the evening meal. The potential weaknesses of recruits were stressed. The ordinance stipulated: 'be sure to take enough time in this task [i.e. teaching psalms and prayers], for old people learn slowly'.[49]

It is clear that the hospital community had been envisaged by its founders as being well-ordered and conducted in a Christian manner. The sixteenth-century Police Order (*Polizei-Ordnung*) that covered the district of Haina revealed that these ideals were also enforced for the local population outside the hospitals.[50] Further details regarding the practicalities of regulating daily life within these institutions can be gleaned from the 1573 ordinance compiled by the superintendent, Reinhard Schenk. Concerning the rooms for the sick and blind inmates (*Krancken- und Blindenstube*), it states: 'As many among the poor suffer from illnesses, severe torments [*Plagen*] and infirmities such as blindness, madness [*Wahnwitzigkeit*], and similar afflictions, the governor and highest officials [*Dienste*] must make a conscientious effort throughout the institutions

[48] Translation from Midelfort, 'Protestant', p. 80.
[49] Ibid, pp. 80 –81.

[*allerorts*] to ensure that these [persons] are well looked after, [that they] are provided with food and drink and that their beds [*Lagerstätten*] are well maintained.' Approximately forty years after the territorial hospitals' foundation, the 'mad' constituted a large enough number among the inmates (in the rooms for the sick and blind at least) that they received special mention. Regarding the expected behaviour of these individuals, the order continues: ' So that they do not forget God's Word, they should practice daily in ... [the following] way ... that one of the brothers reads aloud from the Old and New Testament during mealtimes. Those who are capable are ordered to attend church and prayer, to work, [and] to [practice] concord and harmony [*Eintracht*] and [lead] a godly way of life'. It was ordained that those lacking in understanding [*Unverständigen*] should not be treated with disgust [*soll kein Widerwille gezeigt*], perhaps suggesting that problems had arisen in the past. The emphasis upon community and piety is reaffirmed in the stipulation that 'no sick person should be left alone, but should instead be brought to the common rooms (*Stube*), visited by the pastor, comforted by God's Word and be refreshed with special drinks and foods (*Speisen*)'. It would appear however that not everyone entered into this communal spirit, for it was stated that: 'At the same time one should take care that those [persons]' who help out and serve food, do not 'take away, remove, or misappropriate' any of the provisions.[51]

Life in the territorial hospitals was, in theory at least, strictly regulated. It obviously emphasised the ideals of community, harmony, and a Christian outlook that formed the monastic ideal. This factor should however not lead us to dismiss these institutions merely out of hand as examples of 'Protestant' monasteries. After all, as has been discussed in the previous chapter and as will also be illustrated in the next chapter, it is also possible to locate some innovatory aspects in the foundation of these establishments. For the past two decades, historians have increasingly reassessed the view that emphasised the polarity between Catholic and Protestant practices. This has also been reflected in medical historiography, and the Reformation is no longer seen as marking the

[50] LWV, Bestand 13, Hospitals-Ordnungen und Vergleiche, Polizei-Ordnung für das Hospital Haina.
[51] German transcription in Demandt, 'Hohe', p. 86.

decisive and immediate break in action (especially with relation to poor relief and welfare policies) that it was once accorded. With this in mind, we should not be surprised by the seemingly monastic influences within the hospital order. Studies of Strasbourg and Braunschweig, to name just a couple of places, have noted similar continuities within pre- and post-Reformation practices.[52]

III. Regulated communities.

Heinz Luder's foundation ordinances included 'rules of discipline [*Zuchtordnungen*]'. These potential transgressions were usually 'construed as breaches of fellowship and community'.[53] Infractions were variously punished through the reduction of food, fines, imprisonment, and, finally expulsion. The latter was obviously the hardest sanction. Although inmates were able to reapply, it could take them years to get back into these institutions – the 'dangerous' mad would however normally be readmitted fairly swiftly as they posed a danger to the public.[54] The re-acceptance (*Wieder-Aufnahme*) of former hospital patients who had left the hospital – either through their own choice or through banishment – is a fairly constant, although admittedly not particularly numerous, feature throughout the period. One of the earliest cases involves Henn Cleinhems. He claimed that 'he had been a resident of Haina for ten years but that he had been expelled after getting dead drunk at Treysa (about twenty kilometres from Haina). Now he was repentant and vowed to sin no more if he could only be readmitted, for he would starve outside the hospital. Apparently his appeal was accepted.'[55]

It is clear that the guidelines of the *Zuchtordnungen* were not always followed as stringently as one might assume and allowances seem to have been made for people's actions with regard to their physical and mental states. (This is a subject

[52] Examples of such work include: Winckelmann, Otto, Das Fürsorgewesen der Stadt Straßburg vor und nach der Reformation bis zum Ausgang des 16. Jahrhunderts, Quellen und Forschung zur Reformationsgeschichte 5, New York & London, 1971, (1st edition, Leipzig, 1922). See especially Zweite Teil, p. 23. Boldt, Annette, Das Fürsorgewesen der Stadt Braunschweig im Spätmittelalter und Früher Neuzeit, Braunschweig, 1988; Knefelkamp, 'Städtische', pp. 59 – 60.
[53] Midelfort, 'Protestant', p. 92.
[54] For a brief discussion of this, see Vanja, 'Madhouses', p. 127.

which requires further elucidation, but which is unfortunately outside the remit of this thesis.) It is important to remember however, that we may be receiving a skewed view of this issue. As aforementioned, with regards to these types of 're-petitions', only the successful applications survive (or, at least, have come to light to date). We know nothing therefore of those persons who re-applied for admission and had this plea rejected. Thus we have nothing to compare these cases against to ascertain whether certain cases (and medical conditions) received preferential treatment and / or leniency in these matters. We will return briefly to the issue of misdemeanours and punishments in Chapter Six through consultation of particular case studies. It is useful, however, to briefly comment upon certain aspects of these regulations.

Both Christina Vanja and Erik Midelfort have emphasised the existence of gender divisions within the list of forbidden actions catalogued within these ordinances. The orders for Merxhausen for instance, omitted all reference to the perils of lingering in bed, but offered instead a detailed account of the evils of arguing, cursing, envying, grousing, and gossiping.[56] These women were specifically warned to 'maintain modesty and chastity and to avoid all evil society with men both in words and deeds; and anyone discovered in immorality shall be removed from the hospital'.[57] It would appear therefore that these rules upheld the assumed gendered social divisions of the day.[58] Vanja also argues that these gender distinctions carried over into the petitions concerning mental illness: 'While men were more aggressive than women in general, for women an immodest life was seen as a special sign of mental illness'.[59] This gendered behaviour does not seem to have been transmitted into the medical labels given to these persons – 'men and women were just as likely to suffer from all types of mental illness. Similarly mental illness was not deemed to be attributable to social class, location, marital status, or age'.[60]

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[55] Quoted in Midelfort, 'Protestant', p. 46.
[56] Ibid, p. 82.
[57] Ibid, p. 92.
[58] See among others Wunder, Sun, pp. 174 – 178; Roper, Lyndal, The Holy Household: Women and Morals in Reformation Augsburg, Oxford, 1989; Tlusty, B. Ann, 'Crossing Gender Boundaries: Women as Drunkards in Early Modern Augsburg', in Backmann, Sibylle (hrsg.), Ehrkonzepte in der Frühen Neuzeit. Identitäten und Abgrenzungen, Berlin, 1998, pp. 185 – 198.
[59] Vanja, 'Care', pp. 74 – 75.
[60] Idem, 'Leid', p. 212.

The *Zuchtordnungen* also offer us a theoretical framework of the sharply delineated boundaries of the hospital. This involved restrictions upon the movement not only upon the residents themselves, but also upon the material goods owned by the hospital. Thus, 'no-one should take bread or beer from the table and hide it in boxes or in [their] bed. Those by whom such action is found will be punished ... No-one is to do anything except to sew, to knit caps / bonnets or trousers [*Hauben oder Hosen stricken*], [and] to make purses or cords [*Beutel oder Schnüre machen*] ... None of this [produce] is to be given [away] or sold outside the house [i.e. the hospital], but [instead] each should help the other in the house according to ... [their] ability and without remuneration'.[61] Such a concern to protect one's property evidently had a long tradition. In thirteenth-century Lübeck, for instance, the punishment for selling food outside the hospital was expulsion. Similar policies were in place in Bamberg.[62] Neither was this stance restricted to institutions. A fear that one's goods might be misappropriated is also evident in the section of the 1580 Munich ordinance that related to employers and servants.[63]

The 1573 order further suggests that, once admitted as an inmate, one's movements were severely restricted. Thus, 'no-one should go out of the gate without reason and permission, [n]or to church fairs and weddings, rather everyone should abstain from all [such] immorality [*Leichtigfertigkeiten*]. If a relative arrives, he [or she] should wait at the gate and [some]one would go out to him [or her]'. This person would then discuss with the visitor their purpose for being there and the latter would also receive, if required, a beer, some bread and some soup. [64]

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[61] German transcription in Demandt, 'Hohen', p. 54. (Merxhauser Zuchtordnung für Frauen.)
[62] Knefelkamp, 'Städtische', pp. 65, 70. Similar restrictions can be found in sixteenth-century Florence: Park, Katharine & Henderson, John, '"The First Hospitals Among Christians": The Ospedale di Santa Maria Nuova in early Sixteenth-Century Florence', Medical History, 35, 1991, pp. 164 – 188, here
p. 179.
[63] Wiesner, Merry E., 'Paternalism in Practice: The Control of Servants and Prostitutes in Early Modern German Cities', in Bebb, P. N. & Marshall, Sherrin (ed.), The Process of Change in Early Modern Europe. Essays in Honor of Miriam Usher Chrisman, Ohio, 1988, pp. 179 – 299, here p. 183.
[64] German transcription in Demandt, 'Hohen', p 54. (Merxhauser Zuchtordnung für Frauen.)

Perhaps the best indication of the (theoretical) boundaries of the hospital can be found in the references to the gatekeeper's (*Pförtner*) duties within the 1573 hospital ordinance. The porter, 'a pious and faithful [*getreue*] person' was admonished to open the gates at four in the morning during the summer months, and at 6am in the winter. Time of closure was set at 8pm in the summer and 7pm in the winter - unless otherwise required. The gatekeepers 'must hand over the keys to the governor [*Amtsvogt*, also known as simply *Vogt*] and [must] pick them up from him again in the morning and [they] are not allowed to let anyone in- or out- of the hospital without the knowledge of the governor.' Controlling to a certain extent, the ability of individuals to enter and exit the hospitals, the gatekeepers could potentially have a lot of power. As the ordinance stated: 'When a brother wishes to leave the hospital, he must have a 'special pass' [*Wahrzeichen*]. Those brethren who go [out of the hospital grounds] to work, should only be let in and out in the presence of the governor [*Spitalmeister*]. Herdsmen, field watchmen and foresters, who are active in the fields and woods, and those [persons] who work in the cattle-yard [*Viehhof*] and the infirmary [*Siechenhaus*] are also let in and out at a set time. Those servants such as the cooks, waiters, bakers, smithies, 'cart labourers' [*Wagenknechte*] and manual workers, who earn a yearly salary are not allowed to go outside without permission. Unknown 'foreigners' [*Fremde*], who arrive on foot or on horseback, should wait in front of [either] the outermost or the middle gate. [By contrast,] hospital inmates and tenants from the [area known as the] *Bulsenstruth* [are] to wait in front of the upper gate. [Both groups should wait] until the gatekeeper asks them their business and had reported this to the officials. Then they are either summoned before the gate or are admitted'. These latter rules did not apply to those persons who regularly worked in the 'house'. Their entrance was not to be hindered. The other hospital gates were similarly protected: 'The upper wood – and infirmary gate [*Holz- und Siechenpforte*] is ... only to be opened when wood or other [provisions] are allowed in'. Gatekeepers who were 'negligent or insubordinate' were to be punished or 'relieved of their duties'.[65]

[65] Ibid, pp. 84 – 85.

These boundaries did not just apply to the residents of the hospital, but also to its employees, and to all visitors. In contrast to the Foucaultian emphasis upon confinement, it is clear that the authorities were just as concerned with unauthorised persons entering the hospitals as they were with the residents leaving without permission. The former issue became particularly important during periods of overcrowding. As shown in the previous chapter, the hospital authorities were concerned that persons were illegally being let into the institutions and were benefiting from its provisions – this was especially true of members of the *Gesindedienst*. At a time when Haina and Merxhausen were financially stretched, this issue must have seemed particularly important. Moreover, the period in which Schenk's ordinance was compiled roughly correlates with a time in which the Landgraves were concerned with the potential existence of 'dishonourable officials and servants' working within the hospitals. This fear stemmed largely from the belief that employees of the hospital were failing to list all of the deceased persons and those who had left the hospital into the records. In this way, they were able to use the names of the departed to conceal the presence of other individuals who were illegally working in the hospital (*Hilfskräfte*).[66]

One other likely cause for these regulations relates to the issue of the secularisation of the monasteries and the attempts by Catholic forces to reverse this trend, as alluded to in Chapter One. The strongest claim that Landgrave Philipp the Magnanimous had to retaining these institutions was that he could run them in a more Christian manner than had the monks who previously resided there. Obviously this entailed the maintenance of a good reputation within the locality – an area in which the members of the populace had complained about the monks' gormandising, drinking, and entertaining. The restrictions imposed were to prevent a recurrence of such an event, and would also have stemmed from obvious administrative issues – especially when one considers the aforementioned problems relating to overcrowding and the numbers of hospital population.

[66]Kahm, Otto, 'Geschichte des Dorfes Haina (4). 'Beten, lesen, schreiben', Hessisch-Niedersächsisch Allgemeinen (Frankenberger Allgemeine), unter 'Blick zurück und Notizen zur Heimatgeschichte', 20/09/1996.

It is clear however that the practicalities of these orders were more difficult to enforce. This is highlighted in the section of the 1573 ordinance that relates to the *Große Stube* in Haina. The porters had not been as vigilant as one might have expected – indeed there is a hint that some form of collusion between these staff and the inmates might have occurred to secure the latter's free passage in and out of the hospital. It was specified that: 'it has partially become a habit that some brothers are involved in crafts, commerce and trading and go out to the neighbouring villages and attend weddings and church fairs or [they] find wine and beer there and pass the time in drunkenness, immorality and wantonness, through which [actions they] enrage God [at] the misuse of alms and damage the name [*Ruf*] of the hospital'. Such activities were therefore forbidden. According to the order, whoever disobeyed these rules would be 'thrown out of the hospital'. Once again the gatekeepers were threatened with imprisonment or expulsion if they allowed one of the brethren out of the grounds without proof that this had been allowed.[67]

In spite of all precautions, persons did leave the hospitals. Many did this lawfully – usually because they believed themselves to be sufficiently 'cured' to be able to support themselves. Others however did not. This could prove potentially dangerous in the cases of the insane escaping these establishments, and might also explain the necessity for hospital regulations. Not infrequently, individuals managed to escape on several occasions. Invariably they returned home, an act that both enraged and frightened their families and neighbours. A 1772 letter from the father of Johannes Cammerschmidt is indicative of this situation. Described as *furios*, Cammerschmidt had been admitted to Haina in return for the substantial payment of 200 *Reichsthaler*. He entered the hospital in the early part of 1772. By the time of his father's correspondence in November of the same year, Cammerschmidt had escaped four times and had returned to his home in Volckershausen. On each occasion he had been returned to Haina by a district official – at great cost to the locality. His father Henrich clearly expressed both

[67] German transcription in Demandt, 'Hohen', pp. 85 – 86; also cited in Midelfort, 'Protestant', pp. 90–91. (The latter article seems to use a slightly different version of the document.) For further instances of the regulated movement of patients – in St Thomas' Hospital, London – see Gruber von Arni, E. E., Who Cared? A Study of the Provision of Nursing Care and Welfare for

his concerns and his outrage at this situation. He stated that it had been expected that his son would have been better supervised, especially given the latter's medical history. Clearly it was the community and not the hospital that had to deal with the repercussions of such events. Johannes' mental state was such that all feared for their personal safety because of the potential that this individual had for attacking them or starting fires. Hence, 'no-one trusts themselves anymore, to take hold [of Johannes] and to transport him back' to Haina. Henrich had lost all confidence in the institution's ability to confine his son. He therefore remained at home, constantly fearful that some tragedy might befall him at the hands of his escaped offspring.[68]

Considering the potential havoc that an escaped patient could cause, the hospital officials sometimes made decisions that we would consider baffling regarding who they should send on errands. In the 1706 Haina patient list, for example, those people recorded as acting as messengers included Wilhelm Clemens, a supposedly recovered melancholic, and Johannes Shefer.[69] The latter is described as having 'previously laid in chains'. The reasoning behind such persons' employment in this line of work may be partially explained by the fact that the hospital rules 'never distinguished between the physically ill and the mentally ill'. [70] Theoretically, therefore, all inmates could be classified as 'capable'. Such suppositions did not always prove correct. One case from Merxhausen involves a mentally disturbed woman who was sent to Haina with an important letter. The distance between the two hospitals was approximately sixty kilometres. When she failed to appear at her destination, the official in Merxhausen began to doubt his decision to send her – especially as she was 'a notorious lover of rural festivals'![71] He therefore sent a second message as a precaution. Clearly, the restriction of movement suggested by the hospital orders and the concern with

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Sick and Wounded Soldiers and their Families during the Civil Wars and Interregnum, 1642 – 1660, DPhil, University of Portsmouth, June 1999; Park & Henderson, 'First', p. 179.

[68] LWV, Bestand 13, Patient Strafen (Betr. Wiederholte Ausbrüche des Johannes Cammerschmidt aus Volckershausen hier gefordert bessere Verwahrung, Anno 1723), uncatalogued.

[69] StAM, Bestand 17I, Nr. 2195.

[70] Vanja, 'Tollenkloster', p. 135.

[71] Case cited in Vanja, 'Care', pp. 72 – 73. Unfortunately Vanja does not offer dates for this event. (The only reference that is offered is LWV, Vogtei Merxhausen.) The given time-span of this article suggests that it must have occurred at some point between the sixteenth- and eighteenth-centuries.

the reputation of the hospital did not always tally with the actions of the hospital staff who, in some cases showed an almost laughable lack of common sense.

IV. The 'experience' of illness within the territorial hospitals.

Much of the information cited above obviously reflects an ideal situation, the theory from the vantage point of the Landgrave and the *Obervorsteher* as to how the hospital should be run. (Chapter Six will offer brief insights into transgressions against the expected behaviour and will look at complaints made both by, and about, patients.) It is notoriously difficult to obtain a glimpse of the lives of the sick poor once they have entered the hospitals. They usually only appear in the records in cases of punishment and complaints. In such instances the information given cannot be taken as indicative of general daily occurrences. Further potential sources include patient lists. Usually these offer only the most basic details – often relating to the work that inmates undertook, as will be discussed in Chapter Six. For Merxhausen, parish registers survive which detail the names of the inmates who died during their stay in the hospital. These documents offer us a view of the hospital that has largely been ignored by historical study to date.[72] In addition to logging the dates of death and burial, the pastor often wrote marginal comments regarding these women. He even dedicated a quotation from the Bible to some of them.[73] This latter action has been interpreted as an 'indication that he knew them all'.[74] Consultation of the documents suggests however that another interpretation is possible Some entries in the *Kirchenbuch* are very short, offering little information other than those that can be gleaned from the patient lists. The entry for February 1692, for example, reads 'Elisabeth Tielen from Niedenstein, a hospital sister, ninety-one years old'. Similarly, that for the 3rd October 1671 states 'Catharina Blasin, an old hospital sister who had been in the hospital for over fifty years', and who was buried on

[72] The only other reference that I have been able to find to this source is contained in the brief comments (a few sentences in length) of Christina Vanja in her article 'Madhouses' , p. 125.
[73] The following exmples are taken from StAM, Stadtarchiv Niedenstein, Kirchenbuch Merxhausen (range of entries dating from c.1670 – 1759).
[74] Vanja, 'Madhouses', p. 125. Vanja also states that 'the pastor described the life of every insane sister and dedicated a quotation from the Bible to every one of them.' Certainly the parish

that day. Also interred earlier that year was 'Elisabeth from Rodenburg, an old, one hundred year old [sic] poor sister, who had laid on the bed in the hospital for thirty-one years'. The comment for the 30th December 1672 listed 'Gerdrauth, a poor, mad [*dolle*] sister, who laid in chains for twenty-five years'. None of these entries were accompanied by a Bible quotation.

Sometimes the lack of detail offered is relatively frustrating. We learn, for instance of the 1687 case regarding Margrethe from Nida [sic]. A poor sister, she left the hospital and went home. She drowned in the Eder, near Maternn [Mandern?]. The source leaves us guessing whether permission of leave had been granted, and if her manner of death was connected in any way to her medical condition. In other instances, the individual 'sister' apparently posed as much of a mystery to her contemporaries as she does to us. In March 1692, for instance, Catherle from Simmerhaußen was buried. A hospital sister, the pastor described her thus: '[she was] called 'the Welsh' although no-one knew where she came from, nor what religion she practised. She could also speak no German.'

By contrast, considerable space was devoted to some of the individuals. Many of these instances involve cases of mental illness, although suffering from the latter condition did not necessarily guarantee that a lengthy report will follow. Regarding Catharina von T., who died on the twenty-fifth of January, 1708, the pastor wrote: 'a very miserable [*elende*] hospital sister, all of [her] limbs shook dreadfully, could not lie still anywhere, could also not help herself. Was not well educated [*nicht wohl unterrichtet*]. Doubtless placed her trust in Christ. She wept for the sins that she had committed in her youth through 'whoring' but thought that 'she had deserved the Heaven to which her blessed mother had gone'.[75] This is an interesting admission, as one would not expect such behaviour to fit in with the image of the 'worthy poor'. Catharina was buried on the twenty-ninth of January. In his notes, the pastor dedicated the following Biblical excerpt to her: Ecclesiastes 12, verse 1: 'Remember your Creator in the days of your youth,

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register that I have looked at – presumably the same one – reveals that this is not true in every case.

before the time of trouble comes and the years draw near when you will say, 'I see no purpose in them'.' Comparatively, an entry from September 1690 reads, 'Gießen Elßa, a sister completely without reason [*gantz verstandloß*], who six years ago was suffering from melancholy [*in betrübte Melancholie gerathen*]. According to reports, 'she pushed a knife into her body [so that it went in] up to the handle. God however prevented her death ... When [unspecified] medication had restored her sanity, she was asked by the pastor why she had committed such an act. She answered: 'Oh, forgive me my sins ...'. Thereafter she sat in the 'mad room' [*tollstube*] and had not spoken until approximately two days before her death, when she answered [presumably in response to the repetition of the same question as before] that this time it [her melancholy?] had been better'. The accompanying text was listed as Romans 8, verse 33: 'Who will be the accuser of God's chosen ones?'

Moments of lucidity were relatively common features in the description of madness. We learn, for instance of 'Hommer Elsa (so-called because she was born in Homberg)'. According to the *Kirchenbuch*, she 'had been here for fifty years, confused in mind [*verwirrten Gemütes*] but had 'distinct' [*merckliche*] intervals. Therefore, although she sat in the 'mad room' [*tollen Stuben*] she sometimes spoke quite reasonably [*vernünftiglich*].' She was believed to have been a kitchen maid prior to her illness. '[She] consoled herself particularly often in her misery, that God was her comfort. That is also why she chose her funeral script [*Leichentext*] – Psalm 25, verses 1 – 2: 'Unto thee, O Lord my God, I lift up my heart. In thee I trust: do not put me to shame, let not my enemies exult over me.'

Reference to Biblical quotations also accompanied the shorter notes. For 'Elisabeth Tielen from Niedenstein, a hospital sister, buried, her age ninety-one years', the given text was cited as Luke 2: 29: 'This day Master, thou givest thy servant his discharge in peace; now thy promise is fulfilled.' Similarly in the case of '... T. Martha, a poor diseased [*aussätzige*] hosp'tal sister', the noted Bible extract is much longer than the pastor's comments regarding this sister: '[Has not

[75] I wish to thank Professor Vivian Nutton for his assistance in the translation of the latter part of this quote.

man hard service on earth, and are not his days like those of a hired labourer], like those of a slave longing for the shade or a servant waiting for this wages? So months of futility are my portion, troubled nights are my lot. When I lie down, I think, 'When will it be day that I might rise?' When the evening grows long and I lie down, I do nothing but toss till morning twilight. My body is infested with worms and scabs cover my skin. My days are swifter than a shuttle and come to an end as the thread runs out. Remember, my life is but a breath of wind; I shall never again see good days. Thou wilt behold me no more with a seeing eye; under thy very eyes I shall disappear.' (Job 7, verses 2 – 8). Indeed, it would seem that this Biblical reference offers more detail regarding this individual's plight than the annotations regarding her demise. The quotations that appear to have been chosen for the patient by the pastor are particularly interesting as they offer an insight into an onlooker's perception of another individual's suffering.

The pastor clearly believed that he knew the suffering that some of these women had experienced, and he sought Biblical expressions of this. Of the burial on the 15th September, 1673, of Kunigunde, Henrich Burckhard's wife from Rida [sic], the *Kirchenbuch* reads: '[she] had grown quite numb [*gantz abgestorben*] from the base [*untenan*] [of her body] to the small of her back, so that the flesh fell off [her] thighs, worms were [found] therein and [it] stank tremendously.' The chosen text, Psalm 38, verses 6 – 10, seems particularly apt: 'I am bowed down and utterly prostrate. All day long I go about as if in mourning, for my loins burn with fever, and there is no wholesome flesh in me. All battered and benumbed, I groan aloud in my heart's longing. O, Lord, all my lament lies open before thee and my sighing is no secret to thee. My heart beats fast, my strength has ebbed away, and the light has gone out of my eyes.'

We are given further indication of either at least one aspect of hospital life or of the realities of the medical conditions of various individuals. Of Catharina Varin (buried 23 02/1693) we are told: she 'ate, but did not have much reason [*Verstand*]'. This caused problems with eating when 'she was meant to gobble the food into her body'. Her brain and body did not function in tandem, meaning that 'it was necessary to get such things [food] out of her cheeks and teeth with wooden implements [*Hölzern*] and the like.' Comparatively, of Anna Maria, the

wife of Peter Moller from Riede we learn both about her illness and her life – with the suggestion being that the latter had affected the former. Her husband had left her. Rumour had it that he had run off with her sister, whom he had 'already been sleeping with [*die er zuvor beschlafen*]'. Initially she suffered from some form of accident that affected her mouth. As a result, a piece of her chin had to be removed. Consequently, Anna Maria became nonsensical [*in ihrem Sinn verrückt*], so that she was quite mad [*toll*] and raging [*rasend*]. A few weeks before her death, however, her reason returned. The pastor attributed the following text to her: 'In each of us the Spirit is manifested in one particular way, for some useful purpose. One man, through the Spirit, has the gift of wise speech, while another, by the power of the same Spirit, can put the deepest knowledge into words. Another, by the same Spirit, is granted faith; another, by the one Spirit, gifts of healing, and another miraculous powers; another has the gift of prophecy, and another the ability to distinguish good spirits from false ...' (Corinthians 12, verses 7 – 9).

Interestingly enough, instances of baptism are also mentioned. Although more research is required into this topic, it would appear that the hospital also took in the illegitimate children of their inmates. For instance, in February 1671, Johann Friedrich, the son of Margrethe 'a deaf and dumb sister, who was pregnant' was baptised. He was described as a 'whore child' (*Huhrkind*). His godfather was listed as Ewald Uhbt, the attendant of the sick poor (*Krankenwärter*). Comparatively, on the twenty-seventh of January, 1733, Anna Martha, the 'illegitimate second child' of Anna Cunigunde Rudolffin from Herbelhaußen, a hospital sister, was baptised. Her godmother [*Gevatterin*] was listed as Anna Martha Knatzin, who, as in the earlier case, was also a *Krankendienerin*. The father was reported to be one of the other *Krankendiener*, Paul Knatz. He was described in the report as 'an infamous, wicked person, [a] whoremonger, and adulterer'.

According to the terms of the hospital orders, the pastor was meant to visit the immobile sick – especially those who were close to dying – every day. Just how well the pastor knew the situation of these sisters and the significance of both the length of his inserted report in the church register and of the inclusion of Biblical

excerpts is at present unclear. It could be that the individual sisters chose their funeral reading (*Leichentext*) as in the case of 'Hommer Elsa'. If this were the case however, it is strange that it was not noted in the other instances where a Biblical passage is also cited. The length of time that a sister had spent in the hospital seemed to have no bearing on the detail afforded her in the pastor's testimony. In the longer entries especially, this source offers some indication of life inside one of the territorial hospitals.

In this chapter, we have broadened our view of the *Landesspitäler*, moving from the 'vision' that they represented, as detailed in Chapter One, to consider some aspects of both their physical reality and the lifestyle that would have existed within the walls. Before finally turning in Chapter Four to consider the supplicants who applied to enter these institutions, it is necessary to investigate one other important aspect of hospital life, to gain some notion of what sort of institution a prospective resident could expect to enter when formulating an admission petition. In Chapter Three, therefore, we will look at the role of medicine and medical practice within Haina and Merxhausen. This perspective will largely be three-fold, including a location of these institutions within a wider historiographical framework and an investigation into the part played by medicine in the lives of the applicants, both prior to and after admission.

CHAPTER THREE

THE *LANDESSPITÄLER* AS MEDICAL INSTITUTIONS?

I. Hospital or hospice? Locating Haina and Merxhausen within medical historiography.

We have described the territorial hospitals from the vantage point of their foundation and bureaucracy, their regulated daily routines and their architecture and physicality. In this chapter the focus will shift to the role of these institutions within the medical sphere. Discussion will be undertaken regarding the illnesses suffered by the inmates and also concerning the provision of medicine within the hospital – a subject that has been grossly underrepresented in works to date. In order to offer some wider context to this study, we will first move from the specifically local outlooks of Haina and Merxhausen (the primary focus in this thesis so far) to a theoretical global perspective. The place of these establishments within medical historiography will be considered. Central questions will include: What do we mean by the term '*Landesspitäler*', and how do these institutions compare to establishments that existed elsewhere in Europe during this period? Did the foundation of the territorial hospitals mark a new phase in the Hessian provision of care and relief?

In his study of the formative years of Haina, Erik Midelfort has coined the phrase 'Protestant monastery' to describe the continuities between pre- and post-Reformation Haina. Should we therefore equate these institutions with the religious-based hospitals which prevailed in the medieval period, or are they indicative of the secularisation of welfare policies evident in many parts of Reformation Europe?[1] A prime indicator that Midelfort cites as evidence of this continuity of practice is linguistic usage. Of especial importance are the

[1] A discussion relating to the debate as to the similarities that can be found within Reformation and Counter-Reformation countries is outside the scope of this thesis. For information regarding this historiographical debate, see among others, Winckelmann, 'Fürsorgewesen'; Boldt, 'Fürsorgewesen'; Jütte, Robert, Obrigkeitliche Armenfürsorge in Deutschen Reichstädten der Frühen Neuzeit. Städtisches Armenwesen in Frankfurt am Main und Köln, Köln & Wien, 1984. For a wider discussion, see Zeeden, Ernst Walter, Katholische Überlieferungen in den lutherischen Kirchenordnungen des 16 Jahrhunderts, Münster, 1959; Scribner, Robert, Popular Culture and Popular Movements in Reformation Germany, London, 1987; Po-chia Hsia, Ronnie, Social Discipline in the Reformation: Central Europe, 1500 – 1750, London, 1989.

references to the inmates as 'brethren' or 'brothers', and the usage in the petitions of the word 'monastery' when identifying Haina. (The same process occurred in Merxhausen, although 'sisterhood' was used in place of 'brethren'.) As Midelfort correctly points out, such terminology was prevalent in the sixteenth-century. Thus, for example, in the 1577 petition of Adam Bingeln from Storckelshaußen, in the district of Rotenberg, he requested to be accepted into the *Gotteshaus zum Heyna [sic]*'. Were we to follow Midelfort's line of argument, we would determine that such expressions were an indication that in the public mind at least, Haina was still viewed within a religious and monastic framework. An in-depth study of the hospitals' history over a longer time period leads us to question how much importance we should place upon such phraseology. Had Midelfort glanced at later records, it would have quickly become apparent to him that references to the hospital as a *Kloster* exist throughout the period under consideration and beyond. Thus in 1808, when Kassel wished to make an alphabetical list of all towns, villages and hamlets in the Kingdom (*Königreich*) of Westphalen, Haina was listed under 'K', as 'Klosterhayna'.[2] Even today, as a psychiatric hospital, it still recorded on maps as 'Haina (Kloster)' and is distinguished from the neighbouring village of 'Haina (Löhlbach)'. These examples pose a fundamental question that should be continuously borne in mind: does continuity in language necessarily signify continuity in practice? How are we to interpret Hans Koch's 1629 request to be admitted 'into the hospital or poorhouse [at] Haina'? [3]

Where should we locate Haina and Merxhausen within medical historiography? According to Robert Jütte, the *Landesspitäler* were 'charitable institutions ... [which] were quite unique at the time of their foundation'.[4] Jütte offers no other comment, and to date no-one has questioned this statement. Further comparative regional studies need to be undertaken before we can ascertain with any certainty the 'uniqueness' aspect of the *Landesspitäler.* This does not prevent us however from considering some of their main characteristics.

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[2] Kahm, Otto, 'Ort im Königreich Westphalen', H.N A. – Frankenberg, 13th February, 1988.
[3] LWV, Bestand 13, Reskripte, 1629.
[4] Jütte, Robert, Poverty and Deviance in early modern Europe, Cambridge, 1994, p. 213.

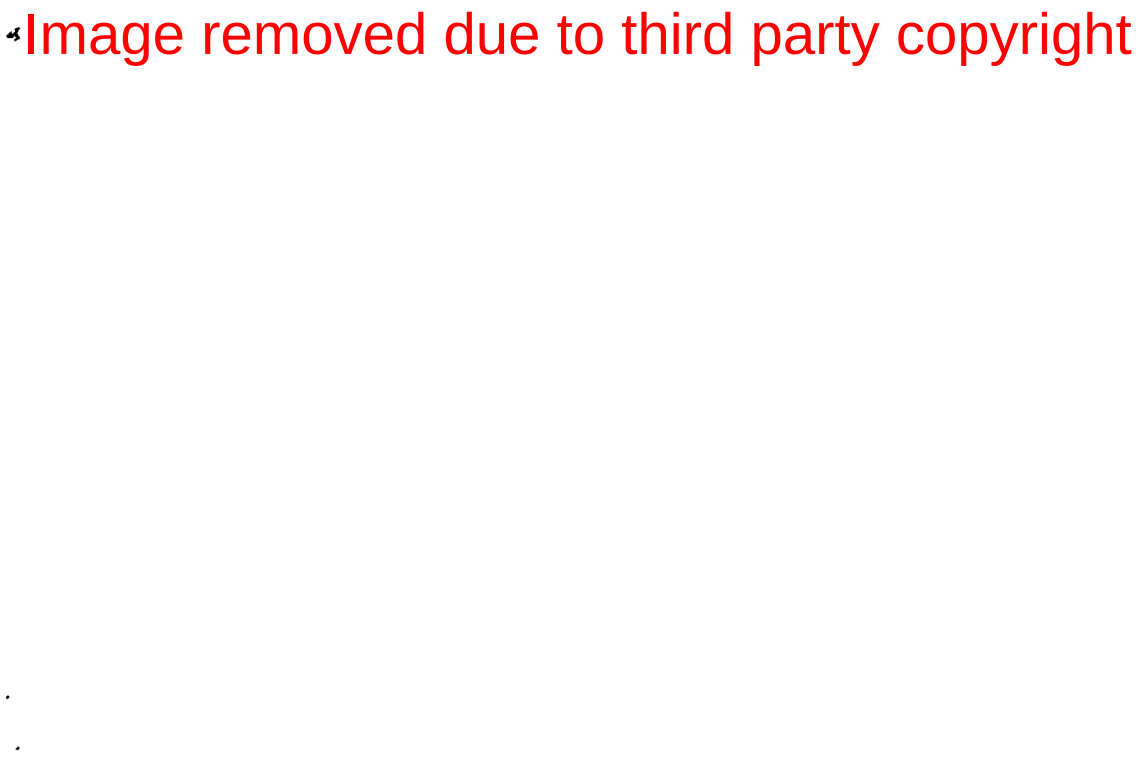

Figure 4. The *Philippsstein*, crafted by Philipp Soldan from Frankenberg in 1542 to commemorate the secularisation of the monasteries (Reproduced by the Psychiatrisches Krankenhaus Haina)

One indication of the intended purpose of the newly-established territorial hospitals might be found with in the stone relief, the *Philippstein* (Figure 4), which was erected in 1542. (Four copies were made - one for each of the *Landesspitäler*.) As Figure Four shows, the imagery on the *Philippstein* is of St Elisabeth, the monks and Landgrave Philipp. The basic premise of the usage of these figures is to equate the work of the Landgrave to his saintly predecessor, which compares starkly to the image of the monks as harpies. This relief not only justifies Philipp's secularisation of the hospitals, but also suggests ways in which the institutions could be used as political instruments, whereby the founder would expect to receive thanks and adulation in much the same way as the lay patrons of urban hospitals.[5] The inscription that is worthy of note here reads: 'Henceforth shall I remain the hospital of the sick poor; to that purpose was I given and dedicated and graciously freed by the Christian Prince of Hesse, Landgrave Philipp, that noble hero, who stretched out his gentle hand toward me – as fine a prize as could be found in the world ... Now am I so endowed, that I receive no man for reward: here the poor man receives out of kindness his food, lodging, and clothing for nothing; and if any other gives other gifts, may God love him, and keep him the better therefor.'[6] As will be shown in this chapter, poverty was not the sole criterion for entrance into the hospitals. An individual's infirmities (whether physical or mental) and medical care also played important roles in the hospitals' ethos.

Regarding the criteria for entrance into the *Landesspitäler*, it has been stated that 'these were the admission requirements for a nursing home, rather than what we

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[5] This is one of many topics in this thesis that I plan to expand upon at a later date. For information regarding the *Philippsstein*, see for instance, Demandt, 'Hohen', pp 57 - 62; Demandt, 'Erbfolge'; Idem, 'Verfremdung und Wiederkehr der Hl. Elisabeth', HJL, 22, 1972. Regarding St. Elisabeth, see Maurer, Wilhelm, 'Die heilige Elisabeth und ihr Marburger Hospital', Jahrbuch der hessischen kirchengeschichtlichen Vereinigung, Band 7, 1956, pp. 36 – 69; Murken, Axel Hinrich & Hofman, Burkhard, 'Die Heilige Elisabeth als Krankenpflegerin. Krankensäle des 15. und 16. Jahrhunderts im Zusammenhang mit Darstellungen der Heiligen Elisabeth von Thüringen', Historia Hospitalium, Heft 13, 1979 – 1980, pp. 7 – 28; Beyreuther, Gerald, 'Elisabeth, Thüringische Landgräfin und Heilige', in Schmidt, Paul Gerhardt (hrsg.), Die Frau in der Renaissance, [Vorträge gehalten anläßlich eines Arbeitsgespräches der Wolfenbutteler Arbeitskreises für Renaissanceforschung in der Herzog August Bibliothek vom 16. – 17. Oktober 1990], Wiesbaden, 1994, pp. 15 – 39.

[6] Translated in Wickel, 'Provincial'. The latter part of these sentiments can be compared to the 1330 motive funding the Elizabethspital in Bamberg. (Reddig, Wolfgang F., Bürgerspital und Bischofsstadt. Das St. Katharinen- und das St. Elizabeth in Bamberg vom 13. – 18. Jahrhundert, DPhil., Bamberg, 1995, p. 31; cited in Knefelkamp, 'Städtische', p. 70.

might today expect of a hospital'.[7] There is perhaps an element of validity to this point, but it must also be borne in mind that these were also the qualifications for entrance into a modern nursing home. In this thesis we are concerned with looking at the *Landesspitäler* in their contemporary context.

One of the main ways in which the *Landesspitäler* differed from contemporary provision concerned the issue of incurables. These institutions were clearly regarded in the public mind as providing a service that could not necessarily be found elsewhere, even within Hesse. Thus in 1744, the director of the workhouse (*Zuchthaus*) in Kassel requested that a former huntsman from Borcken, Carl Henrich Mathaii, was accepted into *Closter Haina*. (Note once again the use of the language.) Medicines had failed to cure Mathaii's ailments and it was felt that, as an incurable, he would be better catered for in Haina.[8] In many German towns, (for instance, in Würzburg and Vienna) the chronically ill were most frequently excluded from the main hospital, residing instead in specialist institutions. The new Viennese *Hofspital* founded in 1551 by Emperor Ferdinand I, specifically excluded the unworthy poor, those suffering from pestilence, leprosy, syphilis (*Frantzosen*), and contagious diseases. It also barred those persons who were 'without reason' (*unsinnig*).[9] Whether the isolated rural location of Haina and Merxhausen offers some form of explanation for its emphasis upon incurability is questionable. With the possible exception of some madness cases, geography seems unlikely to have been a decisive factor. In the incidences of mental illness, the long-term care offered to these inmates and the provision that these hospitals had to care for these types of illness were stressed – particularly if the invalid needed restraining. The fact that the hospitals accepted both the dangerous mad and those simply without reason contrasts with Andrew Scull's findings for eighteenth-century England. Scull suggests that 'only the most violent and destructive amongst those now labelled insane would have been segregated and confined apart from the rest of the community'.[10]

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[7] Midelfort, Madness, pp. 330 - 331.
[8] LWV, Bestand 13, Reskripte, 1745.
[9] Wendehorst, Alfred, Das Juliusspital in Würzburg. Band 1: Kulturgeschichte, Würzburg, 1976, p. 18; Nowotny, Ernst, Geschichte des Wiener Hofspitals, Vienna, 1978, pp. 23 - 24.

The emphasis that the *Landesspitaler* placed upon chronic illnesses makes them comparable in outlook to the *Incurabili* hospitals of Italy and to the *Hôpitaux Généraux* in France. Katharine Park has charted the rise of 'a preoccupation on the part of city authorities and charitable associations with chronic illness among the poor' which commenced in the fifteenth century. This is reflected in the establishment of large specialised hospitals for the incurably sick, some of which were general institutions while others catered for particular groups – the blind, syphilitics, epileptics and the insane. Early fifteenth century Valencia and Seville thus witnessed the creation of the first new mental hospitals.[11] Similarly, the *Hôpital Généraux* established in the seventeenth century, catered for the 'impotent poor or invalids – the aged, the infirm [and] the defenceless'.[12] In contrast to the *Landesspitäler*, however, the able-bodied were also welcomed as inmates - whether the fact that the territorial hospitals predated these institutions by more than a century had a bearing upon this is debatable. The Hessian welfare policies seem to have commenced earlier than many other state system of care. For example, the establishment of the 'common chests' (*Allgemeinen Almosenkasten*) in Kassel in 1526, pre-dated its neighbour Frankfurt am Main by five years.[13] Similarly, the *Landesspitäler* also preceded the seventeenth-century hospitals built in Germany by the Brothers of Charity. Wolff suggests that the latter were the model for the first general hospitals as they took in the predominantly sick whereas most other hospitals were increasingly *Pfründner-Anstalten*, acting as little more than retirement homes for those who could afford to purchase places therein.[14] This study shows that this was not the case.

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[10] Scull, Andrew, 'From Madness to Mental Illness. Medical men as moral entrepeneurs', Archives européennes de sociologie 1975, Volume 16, pp. 218 – 251, here p. 218.

[11] Park, Katharine, 'Medicine and Society in medieval Europe, 500 – 1500', in Wear, Andrew (ed.), Medicine in Society. Historical Essays, Cambridge, 1992, pp. 59 – 90, here p. 89. The patient specifications listed in the foundation ordinances of the *Landesspitäler* contrast with the 1417 orders for Barcelona's new Hospital of Santa Creu. The latter's population was to be 'poor men and women, the crippled, the paralytics, the mentally disturbed, the wounded, and others suffering from diverse human miseries.' Quoted in Brodman, James William, Charity and Welfare. Hospitals and the Poor in Medieval Catalonia, Philadelphia, 1998, p. 67.

[12] Jones, Colin, Charity and bienfaissance: the treatment of the poor in the Montpelier region, 1740 – 1815, Cambridge & New York, 1982, p. 52.

[13] Anon, Kranken, p. 17.

[14] Wolff, Horst-Peter & Wolff, Jutta, Geschichte der Krankenpflege, Basel, 1994, p.88. Compare to Krug-Richter, Barbara, 'Alltag und Fest. Nahrungsgewohnheiten im Magdalenenhospital in Münster 1558 bis 1635', in Ehlert, Trude (hrsg), Haushalt und Familie in Mittelalter und früher Neuzeit, Wiesbaden, 1997, p. 73.

Emphasis was placed upon the notion of the 'worthy poor'. As the chronically ill, their inability to care for themselves made them fit beneficiaries of charitable assistance. Such definitions transcended geographical and religious boundaries in this period. The sixteenth century Englishman, William Harrison, included in his list of the 'worthy poor': 'the aged, blind and lame', the 'diseased person that is iudged to be incurable', 'the wounded soldier', and 'the sicke persone visited with grieuous ... diseases'. [15] Haina and Merxhausen were designed to cater for just such a clientele, although their inmate population also included the mad and the orphaned. These concerns can be compared to Vives' tract *Concerning the Relief of the Poor* in which he wrote: 'I call 'hospitals' those places where the sick are fed and cared for, where a certain number of paupers is supported, where boys and girls are reared, where abandoned infants are nourished, where the insane are confined and where the blind dwell.'[16] The *Landesspitäler* represented an amalgamation of the ideals propounded by both Vives and Harrison.

Notable features of Philipp the Magnanimous' 'vision' of the Hessian territorial hospitals include their rural emphasis, the length of stay of the patients, the division of the inmates within the hospitals, and the segregation of residents according to gender. Another key feature that has already been detailed relates to the theoretical self-sufficiency of these institutions and their communal atmosphere. These themes will be studied in detail in this chapter, and will also emerge throughout the thesis. One important point to note when envisaging these hospitals is that we should not see them as examples of a Foucaultian 'great confinement'.[17] The popularity of the hospitals both belies the notion of enforcement and 'confinement' and also suggests that their foundation was a response to a genuine social need for a section of the populace who had hitherto been forgotten in welfare schemes. As will be shown in Chapter Six, although work played an important role within the establishments, these places cannot be viewed as early examples of the *Zuchthäuser* that were to become prevalent in the late seventeenth and eighteenth centuries. Work was carried out according to

[15] Quoted in Lindemann, Medicine, p. 187. Regarding the 'wounded soldier' see Hudson, Ex-Servicemen.
[16] Cited in Vives, Juan L. Concerning the Relief of the Poor, transl. M. M. Sherwood, New York, 1917, pp. 11 – 12.

a person's capabilities, and, it will be argued here, related more to notions of identity and communal spirit than to profit and business. Whereas Foucault's 'institutions of confinement' predominantly catered for young or middle-aged males, the clientele of Haina and Merxhausen was very different and their physical capabilities suggest concerns that are wholly other than in the hospitals studied by Foucault.[18]

In this chapter we are going to assess the role of medicine and illness in the *Landesspitäler*. This will be carried out through two main foci. Primarily we will look at the residents of these institutions to ascertain the conditions from which these persons were registered as suffering. Such an investigation should allow insight into whether pure poverty or sickness was the overriding characteristic under which these persons were classified. Subjects such as the waiting period for those wishing to enter the institutions and the length of stay in these establishments will also be considered Secondly we will discuss medical practice in relation to these institutions. Our initial concern will be the role of the practitioner both prior to and during the application process. Our final focus will be upon medicine and care within the hospital itself. Contrary to the assertions made in historical works to date – most notably those of Erik Midelfort – we will reveal the role that medicine played within the hospitals throughout the period of study.

II. The hospital population. Suffering and admission: chronic conditions among the *Hospitaliten.*

The population of the *Landesspitäler* clearly numbered more than just those persons who petitioned for admission into the 'brethren' or 'sisterhood', to be cared for 'as other poor persons'. As evidenced in the hospital lists discussed in the preceding chapter, it included those persons who worked in a variety of capacities within these institutions. This latter group can be split into two halves:

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[17] Foucault, Madness, p. 61. For a critique of these views, see among others, Dinges, 'Reception', pp. 181 – 212.
[18] See also the comments in Jones, Charity, p. 56.

the officials (*Beamte*) and the servants (*Diener* and *Gesinde*). The most important officials included the superintendent (*Obervorsteher*), the governor (*Vogt*), the pastor, and the masters in charge of the kitchen and the clothing. All of these persons were closely involved in the various accounting processes that formed the weekly and yearly accounts – the latter of which were studied by the visitation committee. These men were minor nobility or came from the upper classes (*Höheren Bürgertum*). Their backgrounds were as merchants (*Kaufleute*) or senior government administration officials.[19] The former group, (the servants) were employed in a wide variety of tasks throughout the establishments.[20] Their presence in particular highlights the manner in which these institutions were self-financing and also functioned, in many senses, like a village community. Their work included employment in the mill and on the land, cultivating the produce that was then used to provide for the hospital as a whole.

Categorisation also existed among the *Hospitaliten.* It is evident that, from the late sixteenth century onwards, individuals were making payments to the hospital to ensure their placements. This was particularly prevalent in cases of mental illness. Payments also occurred in urban cases of the physically ill, but these have hitherto received no attention.[21] In 1700, for example, Anna Maria, the widow of Johann Adam Strohen, a woolweaver from Giessen, paid for her daughter to enter Merxhausen.[22] The latter had suffered a stroke which had left her lame and mute.[23]

Chapter One has already detailed the Landgraves' perpetual concern that the hospitals did not take in too many rich *Pfründner* (pensioners) and thus become little more than a rural version of the much criticised 'retirement home' style of

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[19] For comment regarding the wives of these men see Vanja, Christina, 'Aufwärterinnen, Narrenmägde und Siechenmütter – Frauen in der Krankenpflege der Frühen Neuzeit', Medizin, Gesellschaft und Geschichte, 11, 1992, pp. 9 – 24, here pp. 16 – 17; Idem, 'Amtsfrauen', pp. 195 – 209. For a discussion of the *Vögte*, see Zillinger, Waldemar, 'Die Vögte von Merxhausen. Aufgaben und Probleme während des 18. Jahrhunderts', in Heinemeyer & Pünder (hrsg.), 450 Jahre, pp. 267 – 280.

[2] Kahm, Otto, 'Geschichte des Dorfes Haina (5). Hospital Arbeitgeber', Hessisch-Niedersächsich Allgemeinen (Frankenberger Allgemeine), unter 'Blick zurück und Notizen zur Heimatgeschichte', 27th September, 1986.

[21] Vanja only comments upon the mental cases. (Idem, 'Care', p. 74)

[22] The payment was either 5 or 50 *R*, depending upon which part of the document one consults.

[23] LWV, Bestand 17, Reskripte, 1700.

many urban hospitals.[24] In spite of this, divisions according to social class existed from the sixteenth century. This initially sprung from cases of the urban mad gaining admission in return for payment, due to the 'danger' that their illness could potentially prove, or to the lack of suitable care in their home domicile. As shown in Chapter Two, the 1575 Merxhausen accounts list two women whom historians believe to have received preferential treatment: the sister of Dr. Moritz Thauer (the personal physician of Landgrave Wilhelm IV) and the wife of Johannes Sachse, the pastor of Dörnberg.[25] Perhaps the greatest indication of this divide manifested itself in the eighteenth century, with the construction of the aforementioned *Honoratiorenbau* [sic] in Haina, for 'patients of standing'.

Patient differential and preferential treatment are areas that would still benefit from much research. One of the most important questions rests upon the issue of inheritance and the bequeathing of one's property to the hospital after one's death – as detailed in Chapter One. This amounted to a variety of payments according to one's capital. Some persons appear to have paid them upon entering the hospital. (As will be discussed, this was particularly true in cases where either elderly parents or newly orphaned siblings were willing to pay either their child or sibling's part of the inheritance to the hospital in return for their securing a place therein.) It would be useful to ascertain whether this also impacted in subtle ways upon the care patients received – or expected to be entitled to.[26] Would for instance, the blind Christian Ludwig from Maltiz have been treated – or envisaged that he should have been treated – differently from other patients, because he paid the hospital 750 *Frankfurter Thaler* (*f. R.*)? How would his expectations regarding care have compared to Johannes Betz, a 'uncomprehending' (*unverständig*) man from Hirßfeldt (sic) who paid 100 *R.* in the same year (1717)?[27] Even if an individual did not leave their 'inheritance' to the hospital until after their death, the authorities still knew of the amount that

[24] *Pfründner* were individuals who purchased places where they might be cared for in their twilight years. For other examples, see Knefelkamp, 'Städtische', p. 64; Schrott, Heiliggeistspital, p. 238.
[25] Demandt, 'Hohe', p. 103, fn 233.
[26] Many complaints from paying patients are to be found in the 1715 Haina documentation. LWV, Bestand 13, Haina.
[27] StAM, Bestand 17I, Nr. 2195.

they could expect to receive. Did this in turn have a bearing on the 'hospital experience' for these individuals? What of those persons who offered to bring bedding and clothing with them?[28] Would they have been accepted into the hospitals more quickly than other persons? This might have been especially important during and immediately after the Thirty Years War at which point the hospitals were experiencing shortages of basic supplies. Quite what the other *Hospitaliten* would have thought about such differentiation would also be an interesting topic of research – although the documentation is likely to be such that we receive only glimpses of information.

A good illustration of divisions within the care of patients is located in the provision of food. The eighteenth century 'kitchen accounts' (*Küchenrechnungen*) indicate that different groups enjoyed different diets. According to Christina Vanja, there were four main categories – students, infirm or physically ill patients, *Pfründer* (pensioners), and ordinary inmates. The first group largely constituted members of academic bourgeois families who frequently suffered from the disease related to the over-stimulation of the brain – melancholia. Their families met their expenses – the so-called *Studentenkost.* This entitled them to the best food – including lots of meat – as well as the best accommodation. Unfortunately Vanja offers no further information regarding the infirm or physically ill patients, nor does she explain how they differed from the last grouping, the poor inmates with no property. It is unclear how these persons can be so clearly differentiated. After all, the majority of the infirm were also poor, and the poor were also ill. Paying patients were, according to Vanja, 'without exception' mentally ill and were either urban residents or were non-Hessian.[29] They had their own servants and lived in separate accommodation.[30] The latter took the form of single or double rooms – provided that they were not suffering from a mental illness that meant that they needed to be restrained in some way. Payment alone does not seem to have secured this differentiated treatment. Contrary to Vanja's assertions, Edith Schlieper has argued that

[28] In 1698, for instance, Anna Catharina Spanaus was admitted to Merxhausen on condition that she bring a bed with her. LWV, Bestand 17, 1698.

[29] This fails to take into account cases which exist of paying, physically ill patients, and the fact that it is sometimes difficult to tell from the sources whether it is an issue of payment per se, or in fact an example of a person giving their inheritance to the hospital whilst they are still alive.

Honoratioren (the later name for patients of standing) were, in special cases, also maintained without payment.[31] It would appear then that at the end of the eighteenth century and within this band of patients at least, social class was sufficient to warrant the treatment that an inmate received. Much more research is required into this aspect of hospital life to ascertain whether we can simply dismiss the appearance of these paying patients, as Midelfort and Vanja have done, as evidence of a corruption of the original vision of the hospital.[32]

Having already discussed the division of patients within the hospital buildings, I will now turn to the patient lists. I will briefly consider the sorts of ailments that the inmates were registered as suffering from. What sorts of medical conditions were catered for in this hospital? What, if anything, does this suggest about purpose of these institutions?

The 1533 foundation ordinance stipulated that the *Landesspitäler* would accept applicants only above sixty years of age, or those who had become so infirm and frail that they were unable to earn enough to feed themselves. Apart from the term '*gebrechlich*' (frail / infirm / impotent), the ordinance does not specify any other illness which were believed to render the patient requiring hospital care. We know however from the 1588 account of Johann Letzener, that from the outset the 'poor' included persons suffering from medical conditions such as blindness, muteness, and deafness, as well as the lame, the crippled, epileptics, lepers and mental patients. A 1548 account by Heinz Luder, the superintendent of the hospital at this time, stated that Haina housed over 200 poor men without means, thirty of whom were blind and foolish (*Narren*). Ten patients were suffering from insanity (*wahnsinnige*) and they were kept in custody. The remaining patients (more than eighty per cent) were 'old, ill, lame', and suffered from a variety of afflictions, including leprosy.[33] Historical study to date has largely concentrated upon the mentally ill patients. As aforementioned, while the

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[30] Vanja, 'Care', pp. 74 – 75.
[31] Schlieper, 'Hohe', pp. 256 – 257.
[32] Midelfort, 'Protestant', p. 93; Vanja, 'Care', p. 74. For examples from the late 16th century and also from the 1621 eating ordinance, see Midelfort, Madness, pp. 349 – 350.
[33] StAM, Bestand 22a, Paket 5.

numbers of mentally ill inmates increased throughout the early modern period, the majority of the petitions concerned physical afflictions.

This section will consider four main aspects of the *Landesspitäler*'s lists of inmates. Primarily details will be given regarding the source-base utilised. Information will be offered concerning how these lists were drawn up, and discussion regarding the temporal variability of the hospital population will occur. This will include an evaluation of the length of the inmates' stay in Haina and Merxhausen. We will then progress to consider the evidence offered by this source-base regarding the illnesses suffered by the chronically ill *Hospitaliten*. Finally, we will turn to the waiting list system to ascertain whether a hierarchy existed amongst the medical conditions, whereby preference was given to certain types of afflictions.

i. Patient lists

The survival rate of the yearly patient lists is more comprehensive from the early eighteenth century onwards. Nevertheless, many examples also stem from the earlier period. With varying degrees of detail, these records provide us with an important source of information relating to hospital life, and enable us to keep track of the individuals who appear within the petitions and to ascertain when and if the theoretical acceptances made by the Landgrave actually became a reality. The sources record the patient's name, place of origin, and illness. Frequently, age is also noted. From the sixteenth century onwards, the entries within these lists were divided according to the Hessian houses (of Darmstadt and Kassel). Other categories of persons who were allowed to admit patients appear in later accounts. These include the chancellor and council, the visitation committee (*Ahnwesende Herrn zur Hainaischen Rechnung*), the superintendent (*Obervorsteher*) and persons accepted jointly by both of the houses of Hesse. The number of admissions that were allowed by these groups is minimal in comparison to the input of the two Landgraves.

It is consistently clear that Hesse-Kassel always admitted more individuals than Hesse-Darmstadt. A good illustration of this division can be found within a list of patients in Merxhausen on 25th May 1701. From a total of one hundred and forty-eight 'sisters', one hundred and six stemmed from the agreement of Hesse-Kassel and thirty-six from Hesse-Darmstadt. The remaining twelve admissions stemmed from officials: ten of these were accepted by governmental deputies (*Deputirten*), and one each by the hospital superintendent and the chancellor and council.[34] This predominant role of Hesse-Kassel is presumably due to the fact that both Haina and Merxhausen were geographically located within its lands, and were thus more easily accessible to persons living within these areas. More research is required, however – not least a contrast with the other *Landesspitäler* - to ascertain whether this is the sole cause.

Comparatively, in the 1720 Merxhausen accounts we discover that Landgrave Carl (Hesse-Kassel) had admitted eight persons that year, while Landgrave Ernst Ludwig (Hesse-Darmstadt) had agreed to only two petitions. This latter number is matched by the acceptances granted by the visitation committee. Neither the superintendent nor the chancellor and council had permitted any new persons to take up residency. Similarly there were no transfers from Hofheim, Haina, or Gronau. (It is interesting that the latter hospital is mentioned, as it is believed to have ceased functioning shortly after the Thirty Years War. Perhaps this reference is a clerical error.) When we consider also those persons who were already resident in Merxhausen that year – i.e. those inmates who were not 'new arrivals' – the lines become more clearly delineated. Of a total population of two hundred and one 'sisters', one hundred and thirty-nine individuals were admitted by the Landgrave of Hesse-Kassel. [35] If we add to this figure the number of Hesse-Kassel's inmates that arrived in 1720, the total figure – one hundred and forty-seven persons – corresponds to almost three-quarters of the overall

[34] StAM, Bestand 17I, Nr. 2282. See also, among others, StAM, Rechnungen II Haina, Nr. 9, Jahrgang 1702, 1707.

[35] An additional four women were described as living *Vff dem Hoff*. All were attendants to the sick poor, and at least two of these persons were wives of *Krankendiener*. A further two (undetailed) children were also included to this list, bringing the total to 'two hundred and five persons, plus two children'. Twenty-two servants were also listed. Interestingly enough, it was specified that this number did not include those persons employed as occasional labourers – in times of building work of harvest. The latter group was instead logged in the weekly accounts. This total population figure included the 'new recruits.

population. By contrast, Hesse-Darmstadt was responsible for the existence of just twenty-four of these women. (Just over a tenth of the total number.)

A further fifteen people were listed in the 1720 records who had (at various times) been allowed entrance as a result of a joint agreement among the two Hessian houses. The overwhelming majority of these women (twelve) were suffering from some form of mental illness. Two of the remaining persons were respectively 'impotent' and 'blind'. The third, Anna Schëfferin, was merely described as Merxhausen's 'old reader'. It would appear that her son had left the *Kloster* that year, following his confirmation. He might have been her only source of care. No information regarding her medical state was offered. With the exception of Anna, the latter group of women came from towns – including Frankenberg, Gemünden, Treyßa, Kassel, Alsfeldt (sic), and Hersfeld. The visitation committee had admitted a total of twelve persons who were still resident in Merxhausen in 1720 – the longest resident had entered the institution in 1676. One person was listed under the heading of 'chancellor and councillor'. (A 'simple' woman, who had arrived in 1694.)[36] Clearly then, the Landgraves of Hesse-Kassel had been the most productive in allowing patients to enter the hospitals. (Similar patterns can also be found for Haina.) Whether this inequality in admissions numbers translated into an unequal power share on the part of this Hessian house is a question that, as yet, remains unanswered.

ii. Length of residence and patient turnover.

From a consideration of the 1720 Merxhausen accounts, it is clear that new patients made up a small proportion of the overall population. When one considers that there were thirteen deaths in this year, the total number of *Hospitaliten* decreased.[37] (As will be shown, the waiting lists indicate that this wasn't necessarily due to lack of demand.) Changes of inmate were fairly common. The 1692 weekly accounts from Merxhausen reveal that the numbers

[36] StAM, Bestand 229I, Hospitalsrechnungen, 1720.
[37] Ibid. Comparatively, in 1715, just fourteen adults and two children entered Merxhausen. StAM, Bestand 229I, Hospitalsrechnungen, 1715.

shifted slightly (through deaths and entrances) in seventeen weeks of the year, meaning that alterations occurred roughly every three weeks.[38]

Once admitted, patients frequently spent many years - frequently the rest of their lives – in these institutions. Records from Merxhausen in 1705, for example, speak of a certain Catharina von Oehlshaußen. Noted as having 'a wooden leg', Catharina had already spent sixty-six years in the institution. Unfortunately her age was not given. While she was not described as 'old', she clearly must have been – a good example of the detail that could be missed if one merely turns patient lists into statistics according to the 'key words' used. Presumably she had entered as a young child. This is doubtless an exceptional case, but it was not uncommon for persons to remain in the institutions for decades. Other examples in the 1705 accounts include Anna from Hohlburn, a mentally deranged (*in haubt verwirret*) woman who had entered Merxhausen in 1662. 1705 thus represented her forty-third year in the hospital. Similarly, Anna Gerdraut von Wattenbach, a woman with failing sight (*mangel an gesicht*) had arrived in 1668. Maria Elisabeth from Homburg ahn der Ohn was listed as an 'old and impotent (*gebrechlich*)' person who had lived in the hospital for thirty-one years. In comparison, Orthia from Hundelshausen had arrived in 1670 and Orthia from Spangenberg had been a resident for two decades.[39]

Such longevity of residence should not lead us to make sweeping assumptions however. Sixty-six of the two hundred and one residents in Merxhausen in 1720 had lived there for five years or less – with forty-one of these persons having arrived since 1717. If we extend this period back to 1710, the number rises to one hundred and nine. [40] Nevertheless, this still means that in 1720 over half of Merxhausen's population had held a place as an inmate for more than a decade – a lengthy period when one compares these figures to the averages found in other hospitals.[41]

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[38] StAM, Bestand 229I, BIV, Paket 25.
[39] StAM, Bestand 229I, Hospitalsrechnungen, 1705.
[40] StAM, Bestand 229I, Hospitalsrechnungen, 1720.

iii. Source critique and patient illness.

Studies of early modern poor relief and the hospital populations have frequently relied heavily upon patient lists to ascertain the ailments that rendered the poor to be institutionalised. In the case of the Haina and Merxhausen records at least, it must be noted that these sources are not without their problems. Indeed, if we assume that some of these same issues are inherent to this type of documentation, we may wish to question some of the conclusions reached in comparative works to date. A wide range of Haina and Merxhausen patient records survive, although their existence is patchy for the earliest years. Comparative research by Karl Demandt for the sixteenth-century has revealed that the sources do not show the exactitude that we would expect from our modern understanding of the term. In his study, for example, some persons were clearly mentioned (and counted) twice in the same year.[42]

In terms of the illnesses listed in these accounts, several points must be noted. Firstly, it is not always clear whether an individual's condition would be recorded differently over a large period of time.[43] Secondly our knowledge of processes through which these lists were drawn up is scant. We know that the highest officials (the pastor, the *Küchenmeister*, etc) were responsible for compiling the yearly accounts. The input of a medical practitioner is (as far as one can tell) lacking. We also cannot tell the level of medical competence of these officials, nor whether they would have known all of the inmates sufficiently well to be able to easily record their afflictions. Was it the case, for instance, that the *Hospitaliten* were visited at the time that these lists were compiled? If so, were the individual patients or the attendant (*Aufwarter*) in each room spoken to regarding the their own (or their charge's) condition, or are the entries the result of the subjective (and visual) opinion of the author of this document? Were the original petitions ever consulted? All of these are important questions. If answered they would allow us to see whether, for example, one type

[41] Carole Rawcliffe, for instance, had described a residency of 'two years or more' as indicative of long-term care. Rawcliffe, Carole, 'The Hospitals of Later Medieval London', Medical History, 1984, 28, pp. 1 – 21.
[42] Demandt, 'Hohe', p. 107.

of suffering was given precedence – was it, for instance, considered more important that a person was frail or lame, and which one of these would be recorded?

In the case of the Merxhausen sources, exactitude becomes more problematic. Prior to circa 1735, the women were rarely recorded with a surname. Usually a Christian name and a place of origin were deemed sufficient. Similarly, illnesses were noted with far less frequency than for Haina. Whether this was related to the individual scribe is unclear. If this were the case, then it also remains fails to explain why these omissions occurred less regularly in the men's hospital.

The historian's use of this type of documentation is crucially important as it would be easy to skew the findings. For the purposes of the statistics below, we are going to make calculations according to the types of illnesses listed. One of the issues that one immediately notes (and that has to date been systematically ignored) relates to the question of old age. As aforementioned, simply being over sixty years of age (and unable to cope) rendered one eligible for acceptance into the hospital. Merely considering the illnesses listed, however, drastically distorts the reality of the situation – a crucial issue that has hitherto remained uncommented upon. Let us consider, for example, the 1700 Haina accounts. Of a total of one hundred and sixty-four persons, only one was listed as 'old'. The full breakdown is as follows: thirty-five were lame and eleven inmates were impotent (*gebrechlich*). Ten persons were recorded as blind and five as simply 'unhealthy' (*ungesund)*. Two persons were suffering from some form of stroke (*schlag*) or, more likely the effects of it. One person was deaf and three were mute. Another person was 'speechless' (*sprachlos*).[44] Seventeen individuals had epilepsy. In total, eighty-six men were listed as suffering from chronic physical conditions. It must be noted that epilepsy was often seen as being connected to mental illness – this was the main 'cross-over' case between physical and mental ailments, whereby the epilepsy frequently affected a person's mental capacities. If this had

[43] In her case study, Aline Steinbrecher has suggested that a diagnosis of *geisteskrank* only referred to one specific moment. Steinbrecher, 'Schiksal', p. 354.

[44] In addition, a seventy-three year old man was registered as '*cum uxore*'. If this really is the case, it must be noted that his wife is not included in this patient list – thus bringing into question the accuracy of these records. (No reference to his age is made in these notations).

occurred in any of these cases, it has not been recorded. At least in the eyes of those compiling lists – if not in the opinions of other persons also – these individuals were solely recognised as epileptics.

Fifty-nine individuals were suffering from specifically mental illnesses – twenty-seven persons were 'without reason' (*unverständig*), twenty-two were 'silly or nonsensical' (*Blöden Verstands*). Four inmates were listed as 'furious' (*rasendt*), one as 'simple' (*einfältig*) and one as melancholic. In addition, one individual was described as imbecilic (*blödsinnig*), one as 'silly [in the] head' (*blödhaupt*) and one as mentally deranged (*verrückt Verstands*). Another individual was simply listed as being 'without reason' (*ohn Verstand*). [45]

In addition, one inmate was a 'foundling' or orphan (4 year old 'Christoph Findeling'), one a dwarf, and eight were simply poor. (One of the poor was additionally deaf.)[46] No explanation was offered in eight cases.

Were we to present the facts in this way, we would conclude that, in 1700, old age had ceased to be an important category of admission. Such an assumption would be entirely false. The lists also include an additional category – the age of the patient. Consultation of the latter results in the emergence of a wholly different picture. A total of thirty-one persons can now be considered 'old' as the hospital understood it (i.e. sixty years of age or older). (Only one of the one hundred and sixty four people was not given an age.) Indeed, whereas the sole old person in the 'illness category' was sixty-six years of age, many of this group of thirty-one persons were older than this, but were still described in terms of another affliction. It is not clear why this should be the case, but it strikes an important note of caution into these proceedings.

A study of the age-distribution statistics offers some interesting insights into the makeup of the resident population. Far from being a hospital predominantly for the elderly, the figures for 1720 reveal that, in this year at least, a fairly even

[45] StAM, Bestand 17I, Nr. 2195.
[46] I have not counted this 'poor and deaf' man amongst the deaf, thus avoiding the problem of adding two entries for one person.

spread is found throughout a wide range of ages. The largest group of people (seventy-nine persons) can be found in the twenty- to forty years age bracket. Forty-one of these men were aged between twenty and thirty years. Fifty-two men were between forty-one and fifty nine years of age. The smallest number of individuals was in the lowest age bracket – those of twenty and under. (The latter might be explained by the mechanisms of familial and communal care networks, as will be discussed in Chapter Five.) An in-depth comparative study of these patient records is required to chart changes in the age-makeup of the *Hospitaliten* throughout the early modern period. Patchy survival rates of the sources – particularly prior to the eighteenth century – and the sporadic way in which age is detailed in the accounts may render this enterprise problematic.

As discussed above, the Merxhausen records frequently offer much less information than those of Haina in relation to patient age and illness. The 1720 accounts list the medical conditions of the two hundred women patients. Of these, fifty-eight females were noted as suffering from mental illnesses and one hundred and twenty-seven from physical ailments. In the former section, the most popular description was 'simple' (*einfaltig*) – thirteen women – followed by 'mentally deranged' (*haubt verwirrt*) – nine women. Six individuals were described as having problems reasoning (*nicht recht beÿ Verstand*) and four persons were 'without reason' (*verstandloß*). The same number were 'non-reasoning' (*unverständig*). Three women suffered from each of the following categories: 'silliness of reason' (*blödes Verstands*), 'in delirium', 'crazy' (*wahnwitzig*), and 'insane' (*wahnsinnig*). Two women were melancholic, two had 'weak powers of reason' (*schwaches Verstand*) and two were 'raging' (*rasend*). One person was not '*sane mentis*'. The other three persons had lost their sense or reason, being variously described as *unsinnig* ('nonsensical'), *blödsinnig* ('silly') and *sinnloß* (literally 'senseless').

Of the physical conditions, 'impotent' (*gebrechlich*) and 'lame' were by far the most common afflictions, being mentioned on thirty-three and forty-eight cases respectively. 'Impotence' (*Gebrechlichkeit*) was mentioned as an additional category on seventeen cases and lameness in two. For instances, both of the 'poor' persons were also deemed '*gebrechlich*'. Twenty persons were described

as 'old', and this was given as a secondary term in twelve additional instances. Eighteen women suffered from the 'falling sickness' – interestingly it was only ever called 'epilepsy' on one of these occasions. Other illnesses were attributed to smaller groups of women. A total of eighteen individuals had problems with their eyesight. Six were described as 'blind', six as 'terrible sight' (*blödes gesicht*) and six as having a 'lack of sight' *(mangel gesicht)*. Four females had a 'lack of hearing' (*mangel gehör*) and three were mute. One person was 'speechless', one had cancer and one asthmatic (*dampfsicht*). One case of spleen problems (*Miltzbeschwerung*) was registered. The leg and arm of one individual was described as 'crooked'. This person was also deemed lame.

Of the cases in which more than one condition was registered, only seven crossed the barrier between a physical and a mental illness. In five of these cases, the physical affliction was noted first (e.g. lack of hearing and reason; lame and 'not right by reasoning' - *nicht recht beÿ Verstand*; old and crazy; old and a lunatic). In two instances, the mental state of the female was listed first. One concerned a description of *blödes Verstand* and 'impotent', the other was 'simple' (*einfaltig*) and suffering from the 'falling sickness'.[47] We can perhaps assume therefore that epilepsy was only once connected to a mental illness. Whether these states were deemed to be independent of each other however remains unclear from the patient lists.

iv. The language of illness.

How are we to interpret such data? Studying these two documents suggests that the predominance of physical conditions among the hospital population continued into the eighteenth century. Moreover, the lists suggest that women and men were deemed to suffer from the same types of mental illness, although in differing numbers.[48] The twenty-year gap in the composition of each of these documents may render this incorrect however. Similarly, more research would

[47] StAM, Bestand 229I, Jahrsrechnungen, 1720.
[48] It may indicate a continuation of the similarities noted by Midelfort in his study of sixteenth-century cases. Midelfort, Madness, p. 364.

need to be carried out to prove the notion that women were more often described as *gebrechlich* than men. One point that is clear relates to the frequency with which the term 'lame' was ascribed to a patient. This is comparable to the situation unearthed by Margaret Pelling in the 1570 Norwich census, suggesting perhaps the universal and timeless quality of these afflictions and their effect upon the poor in particular. In the Norwich records, the most common term was also 'lame'. 'Falling sickness' was similarly popular. Blindness was also more frequently cited than deafness. In contrast to the German situation, however, the second most common phrase in the Norwich records was 'sick', 'very sick' or 'sickly'.[49] This is rarely mentioned in either the petitions or the patient accounts as a predominant ground for hospitalisation.

Perhaps the most important consideration that a study of the patient records offers us is the relatively limited nature of information that they impart. This is especially the case if one compares these documents to the petitions. It is clear from the latter source, that individuals most commonly catalogued a range of ailments and conditions, rather than attributing blame to one particular malady. Sometimes these are seen as an interconnected whole, at other times they are not. One can scarcely glean such a multiplicity from the patient lists. Indeed, even when more than one category is entered, a cautious approach is advised. This issue proves problematic on two levels. Firstly, how are we to tally such occurrences without altering the statistical results? What happens if, as occurs in some lists, some persons are noted as having two afflictions while others have three? The quandary in these instances lies not so much in the mathematical procedures involved in representing such data, as in how we 'quantify' them. This brings us to our second point. How are we to ascribe a hierarchy to these alternatives – and should we do so? If one person is, for example, 'lame and infirm' while another is just 'infirm' do we attribute the same weighting to the 'infirmity' of the first person as to the second? Could it not be that the lame state of the first person made them appear 'frail' or 'infirm'? One of the main problems in such queries is that we do not know by which measure each person's condition was decided upon.

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[49] Pelling, Margaret, 'Illness among the poor in an early modern English town: the Norwich census of 1570', Continuity and Change, 3, (2), 1988, pp. 273 – 290, here p. 281.

Another crucial issue at play here involves our understanding of the terminology of these lists. As aforementioned regarding the word '*siech*', this word does not always seem to have been attributed the same meaning. *Gebrechlich* is a similarly problematic category. The vagueness of this term is highlighted by the 1715 patient list for Haina. Here a specific column was assigned to list the *gebrechlichkeiten* that a person was suffering from, be it both a mental or a physical affliction. In this sense, therefore, the word was a catch-all term for all of the conditions that afflicted the inmates. As if to prove the confusing nature of this expression, however, some of the patients were still listed as *gebrechlich*.[50] Quite how it could mean both things at once is unclear. [51]

Such linguistic issues have led Erik Midelfort to criticise 'the often impossibly vague language regarding the poor.' He blames this on the fact that: 'the petitioners had no real interest in or familiarity with medical diagnosis...'.[52] This does not appear to be an entirely fair appraisal of the situation. To the modern reader the terminology undoubtedly appears vague. One can assume however that to the early modern person such words had a meaning that is lost to us today. Moreover, it is obvious from the patient accounts (and, as will be shown, from the petitions) that there was no specific indication of medical terminology. Latin words – such as *melancholici, maniaci, epilepticus* – occurred with far less frequency than their German counterparts. Thus the mentally disturbed were listed as '*Verrückte*' or '*Verwirrte*' and the epileptics were described as '*Fallsüchtige*' or as being plagued with 'falling sickness' (*mit der schweren / fallenden Krankheit beladen*).[53] It is unclear how much – if any – input a medical practitioner would have had in drawing up the details of inmates for the yearly accounts. Such an omission may thus explain the vernacular nature of much of the vocabulary used. Nevertheless, as will become clear later in this chapter, until at least the beginning of the eighteenth century, little differentiation can be made

[50] StAM, Bestand 17I, Nr. 2195.
[51] Regarding this issue of the problems of cross-century translations, see Siefert, Helmut, 'Vom Hohen Hospital ...', Merxhausen in Geschichte und Gegenwart. Vom Hohen Hospital zum Psychiatrischen Krankenhaus. Festvortrag zur 450-Jahrfeier im Psychiatrischen Krankenhaus Merxhausen am 27. August, 1983, unpublished paper, p. 9. For a brief discussion regarding early modern medical terminology, see Wear, Andrew, 'Puritan perceptions of illness in seventeenth century England', in Porter (ed.), Patients, pp. 84 – 87
[52] Midelfort, 'Sin', p. 126.
[53] For comments relating to cases of mental illness, see Vanja, 'Care', p. 75.

between the expressions used by the doctors and surgeons and those of the lay poor. Instead of 'lacking' a 'medical diagnosis', the lay poor were using the same language as their learned contemporaries.

It is the contention of this thesis that we should give allowance to the linguistic subtleties of the early modern period, even if we may not fully understand their meaning. In contrast to other studies of this style of source base, this thesis has deliberately counted each different term as a single category, instead of lumping together words which have similar meanings – such as *'verwirrte'* and *'verrückte'*, which can both be grouped as 'mental derangement'.[54] The reasons behind this method are simple. If we make assumptions regarding this vocabulary, we are potentially in danger of distorting the issue. Even if two categories have similar meanings and even if the literature of the period would join two concepts together, we should not necessarily assume that the person (or persons) compiling these accounts would also do so. Differentiation, however, slight, has obviously been made in the mind of the individual assessing the ailments of the patients. Thus, for instance, in the 1720 yearly accounts from Merxhausen, there are three categories listed that relate specifically to eyesight: *blind, mangel gesicht,* and *blödes gesicht.* We could confine all of these terms under the heading of 'blindness', but would this truly represent the reality? Could it not be that *'mangel gesicht'* and *'blödes gesicht'* are stages of failing eyesight that eventually lead to blindness? It could be argued that in the wider picture such detail is unimportant. We could just classify these as 'eye problems' and leave it at that. For the nature of this study, however, such detail could be crucially important. Whether one's eyesight was failing or whether it was completely lost would be of fundamental importance to a person's self-perception and experience of illness. Moreover, it would have a huge impact on their capacity to perform certain tasks – at least in the short term. If we are merely to gloss over such subtleties, we would also be in danger of falsely representing the hospital population according to the way that their contemporaries viewed them.

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[54] Compare to the methods used in Midelfort, Madness, p.364; Steinbrecher, 'Blödigkeit', pp. 53 - 69.

v. Waiting lists, illnesses and admissions policies.

The popularity of the *Landesspitäler* prevented many accepted applicants from immediately entering the hospitals. Considerable waiting periods were not uncommon. During such times, the applicant would usually be offered some support from the hospitals in the form of *Wartegeld* (literally 'waiting money).[55] For some, the wait proved too much, and they died before gaining entry to the institution.

The 1747 Merxhausen yearly accounts (*Jahrrechnungen*) offer us interesting insights into both the admissions process and the problems of overcrowding. At the end of 1746, seventeen persons were listed in the Hesse-Darmstadt acceptance list as awaiting entry into Merxhausen. Two of these cases stemmed from 1739, four from 1742, one each from 1743 and 1744, and two from 1745. An additional six persons joined the waiting list in 1746. The conditions suffered by these individuals ranged from the blind step-sister of Nicolaus Rüppel from Biebra [sic] in the district of Grebenau (who was theoretically granted a place in 1739) to Eliesabeth, the imbecilic (*blödsinnig*) daughter of Jonas Schreiber (whose entrance was also permitted in 1739, 'space allowing'). None of these applicants were received into the hospital before the May 1747 accounting period.

As has been shown, in the numerous *Jahrrechnungen* that I have consulted, Hesse-Kassel consistently allowed more people into the hospitals than Hesse-Darmstadt. This trend is also reflected in the waiting lists. In the 1747 records Hesse-Kassel still had seventy-six people awaiting entrance. The lists reveal that nine of these petitioners were admitted into Merxhausen in this year. Interestingly enough, all those who entered did so within the *secundum ordinum* class. It is important to note that a number of these expectant patients were elderly. For instance, Johann Adam Schönsten's seventy-year old impoverished widow had been waiting since 1742. Werner Haten's sixty-seven year old, poverty-stricken wife from Oberkaufungen had been on the list since 1745, as

[55] For a brief discussion of the *Wartegeld* system, see Stöhr, 'Armer', pp. 91 – 96.

had the frail, sixty-two year old Anna Gela Ohlsbaumin from Halßdorff. Neither were cases of mental illness exempt from this delayed entrance. The forty-two year old daughter of Hanß George Siebel (from Wickensroda in the district of Lichtenau) who was 'nonsensical' (*unsinnig*) had theoretically been granted a place in 1739.

At present, only unsubstantiated conjectures can be made regarding this aspect of the admissions process. A fundamental point to note relates to the issue of payment. It is not possible to merely reduce the entrance policies of these hospitals to those of the urban hospitals which were criticised for being little more than retirement homes for rich burghers who paid their way in, and from whose ethos Landgrave Philipp the Magnanimous wished to distance his state welfare policies. While some individuals did offer the money payment to secure a place in the hospitals, this did not necessarily ensure that a person would receive preferential treatment. It is important to note that from the late sixteenth century, applicants were increasingly encouraged to bequeath and property or wealth that they might have to the hospital upon their death – provided that they were without children who would otherwise inherit these monies. It would appear that in some cases persons preferred to do this at an earlier date if they felt that they or the invalid – if an application was made by a third party – would spend the rest of their days in the establishment. Quite why this was so, and whether they believed that such a gesture would grant more favour to their case, is unclear. It is evident however, that some of those who paid monies also had to wait to be admitted. The 1747 waiting list also included individuals who were paying certain sums to the hospital as part of their applications. These cases included Martha Eliesabeth Wiegandin from Ostheim in the district of Melsungen. A poor and infirm individual who had been 'accepted' in 1744, her entrance would secure a payment of 40 *R* to Merxhausen. Examples from 1745 include Agneßa Schneffin who was lame, and the imbecilic (*blödsinnig*) Catharina Eliesabeth Hammerin from Frielendorff, both of whom had each promised a 50 *R* donation.

We are also unable to explain the reasoning behind the fact that although Hesse-Darmstadt was unable to shrink its waiting list in this year, it nevertheless

secured the admittance of six women. Only two of these cases were accepted as *extra ordinem*, probably due to the severity of their conditions and the danger that the individuals posed to society. One of these persons, the Pfarrerin Stuhlmännin from Treÿßa was described as raging (*rasend*). The other women all fell into the *secundum ordinem* category. They were admitted free of charge, and would live at the general expense (*Gemeine Kost*) of the hospital. Two of these individuals were listed as lame, one as blind, and one as frail (*gebrechlich*). On the Hesse-Kassel side, those nine persons who finally moved from the waiting list to Merxhausen were all accepted free of charge, *secundum ordinem* and according to the *Gemeine Kost.* Where the conditions were listed, we learn that three of the women were infirm, one lame, and one blind. A further two cases related to some forms of mental problems. One individual was simple and another was without reason. (One of the persons listed as having been accepted from the waiting list does not appear on the list of those admitted in 1747. Such minor faults reiterate the necessity of using this source base with caution.)

But what of the persons admitted by Hesse-Kassel who seemingly avoided the waiting list and entered Merxhausen in 1747? Apart from one case involving someone who is described as 'confused in [the] head' (*im Kopf verwirth*), the remaining (four) admissions were *extra ordinem.*[56] Thus, the 'senseless' (*sinloß*) Maria Eliesabeth Curtin from Löhlbach entered Merxhausen on the 19th of July. Another woman 'without reason' (*nicht verstand*) arrived on the 21st March.[57] It would seem reasonable to assume that these applicants were all admitted as a result of the issue of safety and the severity of their derangement. What remains unexplained however is why, for instance, one lame and three infirm individuals were admitted free of charge, when there was at least one lame and one infirm applicant on the waiting list who would have been willing to make a payment to secure their entrance into the hospitals? Such questions can only be answered (if at all) through further research that has proved outside the scope of this study. A variety of explanations can be offered. In the aforementioned 'payment cases', it may well be that the individuals involved had been unable to honour their offers.

[56] Vanja states that if a case was *extra ordinem* a person was received immediately. Vanja, 'Gemütskranke', p. 3.
[57] StAM, Bestand 229I, Jahrs-Rechnung, 1747.

I suspect however that other complex issues are at work which relate more closely to politics and networking. As aforementioned, Karl Demandt has suggested that, at the outset at least, certain districts were allocated a quota of places within the hospital – although as he himself admits, he has been unable to discover exactly what this entailed; in short, it is more of a supposition.[58] Issues such as possible patronage links or preferential treatment are further areas of research which require more study. It would be important to discover whether it was more beneficial for the local officials of the area from which a particular application may stem to be on good terms with the Landgrave, the superintendent, or a member of the visitation committee. In other words, although the applications are, on paper at least, overwhelmingly accepted by the Landgrave of one of the two Hessian houses, was it, in reality, the Landgrave alone who could speed up the entrance to one of the territorial hospitals once admission had theoretically been granted? It would seem logical that this latter process would fall more clearly within the remit of the superintendent who was in charge of the daily running of the hospitals, or indeed within the powers of members of the yearly visitation committee who evaluated the performance of these institutions. As already stressed above, such comments are merely suggestions. Nevertheless, further investigation into such issues is necessary to give us both more information regarding the operation of Haina and Merxhausen and greater insight into the actual power base within Hessian state administration.

A study of the patient accounts suggests the quintessential part played by an individual's identity as a sick person. The *Landesspitäler* were therefore not merely poorhouses – the category of pure poverty is rarely entered in these lists. Normally a *Hospitaliten*'s residence in the institution was justified by their mental or physical condition. As has been amply illustrated however this source base is not without its problems.

[58] Demandt, 'Anfänge', p. 191. Demandt's comments refer specifically to Hofheim. Presumably this situation also existed in the other *Landesspitäler*.

III. Medical provision within Haina and Merxhausen.

The early modern Hessian *Landesspitäler* were not hospitals in the modern sense of the word. To a large extent, many of the historical studies of these hospitals to date have either assumed that this factor must equate to a complete dearth of medical provision, or they have ignored the issue entirely. Thus Erik Midelfort has asserted that the 'hospital[s] made no provision for medical care, and ... the founding ordinance assumed that sickness was the last stage before death.'[59] As will be shown, this statement wholly belies the reality of the situation.

An explanation of the lack of space that this topic has been granted to date may lie in both historians' preconceptions regarding the limited amount of medical care evident in early modern hospitals combined with a lack of obvious documentation detailing such practices. Admittedly, the surviving sources regarding aspects of medical care are relatively sparse prior to the 1730s (from which time, detailed medical accounts from the barber surgeon / apothecary survive), and their location is not immediately obvious. Nevertheless, the comparative paucity of evidence from the sixteenth- and seventeenth-century as opposed to the later periods is insufficient to explain the near silent treatment that this topic has received to date. For instance, in the aforementioned collection of essays entitled *450 Jahre Psychiatrie in Hessen*, medical treatment prior to 1881 is afforded a fifteen-page study (in a book of some 460 pages).[60] The research focuses only upon one of the hospitals (Merxhausen), and it restricts itself to considering surgeons (*Chirurgen und Wundärzte*) within this hospital from 1696 to 1881. The greatest focus falls, perhaps unsurprisingly, upon the later period, with only four pages being devoted to the period prior to 1750.[61] By contrast, a study in the same volume, concerning the forests of Haina and Merxhausen in the sixteenth century has twenty-five pages devoted to it.[62]

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[59] Midelfort, Madness, p. 333.
[60] Grebe, Hermann, 'Über die Chirurgi und Wundärtze am Hospital Merxhausen (1696 – 1881)', in 450 Jahre, pp. 281 – 295. Other references are minimally scattered throughout the book, especially in Schlieper, 'Ernährung'.
[61] This includes general, introductory comments that are not specifically dealing with a medical subject matter.
[62] Boucsein, Heinrich, 'Die Forsten der Hohen Hospitäler Haina und Merxhausen im 16. Jahrhundert', in 450 Jahre, pp. 185–209.

This prior lack of historical investigation into the medical care provided by the hospitals is a bias that this thesis hopes to rectify.[63] One possible cause of this omission relates to the fact that medical care (in the sense of doctors, surgeons, etc.) is not specifically mentioned in any of the hospital ordinances. The nearest that one comes to finding any such references is within the remits of care within a wider sense, akin to that of a hospice, whereby one received shelter, food, and clothing.[64] The preamble of the Merxhausen *Salbuch* of 1557, emphasised the aim that those who entered the hospital should be maintained (*erhalten*) and looked after (*versorgen*). The poor inmates were to be provided with food, drink, clothing and bedding to the best of the ability of each institution.[65] Comparatively, instructions for the attendants of the sick which date from the second half of the seventeenth century, emphasised the importance of cleanliness, warmth, and the provision of food and drink. A 'night watch' was mentioned for the 'sick room', whereby patients would presumably receive attention twenty-four hours a day.[66]

The fact that patients had to be suffering from an incurable condition has similarly led some historians to falsely assume that this factor rendered medical provision unnecessary - as is evident in Midelfort's aforementioned assertion that it was 'assumed that sickness was the last stop before death'. It must be remembered however that many of the petitioners had been 'sick' for many years prior to making an application. Their illnesses were predominantly of a chronic and non-fatal type. As will become increasingly apparent in due course, ailing individuals realised that they were likely to die through neglect or starvation if not admitted to the hospitals, as their medical state rendered them incapable of caring for themselves. It was therefore, overwhelmingly the effect upon a person's capability to fend for themselves rather than the 'sickness' itself that was likely to cause their death. While the correspondence contained requests that they be admitted to a *Landesspital* for the short time that remained of their lives -

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[63] For examples of the brief comments that this topic has hitherto received see Vanja, 'Madhouses', p. 130; Vanja, Christina, 'Das Frühe Hospital Haina', in Boucsein et al (hrsg), 800 Jahre, pp. 78-79; Wickel, 'Geschichte', pp. 201-202.

[64] Regarding the increasing important role of food in hospitals from at least the medieval period, see Knefelkamp, 'Städtische', pp. 60, 63-64; Risse, Guenter B., Mending Bodies, Saving Souls. A History of Hospitals, Oxford, 1999, p. 211.

[65] Cited in Demandt, 'Anfänge', pp. 204 – 205

especially in cases of aged supplicants - it has been shown that many inmates resided in these institutions for many years. For the most part, these were not the types of 'sickness' that were 'the last stop before death'. As will be illustrated in due course, some people were even sufficiently 'cured' to leave the hospital.

While not denying the important role of religion in hospital life - nor indeed that of food and basic levels of care - this thesis wishes to correct earlier misconceptions to reveal medicine's central role in the *Landesspitäler*. It is important to prove that this care existed from the outset. This was an extension, and in many respects a continuation, of monastic practice within these institutions, evident in the existence of both an *Infirmatorium* in Haina from the thirteenth century and also an apothecary shelving unit in the same institution which is believed to date from the fifteenth century.[67] The second section of this chapter will assess the role of medicine within the lives of the sick poor from three main perspectives. Primarily we will consider both medicine's place prior to an individual's application, and also the role of medical diagnosis in the petition process. Discussion will be undertaken as to the effects that a search for a cure had upon these sick individuals before they entered the institutions. Finally, we will prove the existence of medical provision within the territorial hospitals and will also comment briefly upon the appointment of medical practitioners.

i. Access to and utilisation of medical treatment prior to hospitalisation.

While it is not until the 1728 ordinance that we have a definitive statement that only petitions that were accompanied with a medical report would be considered, this process began much earlier. It does not appear to have occurred across the board however - although this may be explained by the survival rate of the available source material. In some cases, reports from doctors and surgeons are missing from the petition although we know from references elsewhere in the

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[66] StAM, Bestand 17I, Nr. 2296.

[67] Franz, E. G., Kloster Haina. Regesten und Urkunden, Band 1, Marburg, 1962, Nr. 546; Demandt, 'Anfänge', p. 221; Idem, 'Hohen', p. 100.

manuscript that this correspondence existed. For instance, the Landgrave's letter would comment that 'as we can see in Dr –'s report...' but the paperwork in question is (frustratingly) missing. In other cases it appears doubtful that a full medical report ever accompanied the petition, although we know that the individual had consulted a doctor prior to application. In Agneta Linnemann's 1716 Merxhausen case, for example, we learn of the doctor's testimony in a copy of a letter sent by the officials of Homberg. In compiling the original paperwork, these officials had arranged for Agnetha's condition to be assessed by the town physician, Dr. Chuno. The reader is offered a summary of her situation which was produced by the officials but which doubtless mirrored the findings of the medical examination. In the doctor's opinion, the individual '[is] not only a simple [*einfältige*] person and is 'silly' [*albern verstands seÿe*]', but there was also no hope of her being cured by medicine. In addition, she was 'almost continuously sickly and weak'. Moreover, according to those persons for whom she had worked a few years previously, she was incapable of earning a living.[68] The officials appear to have amalgamated all of the strands of their investigation into one report. The precise reason for this action is unclear, although it may be in some way connected to financial considerations. Obviously this is not really a medical report in the modern sense of the word, but more a commentary of facts which are either visible to the eye, or which can be gleaned through conversation. Nevertheless it reveals the crucial role played by medical diagnosis in the application process.

As one would perhaps expect, it was not until the late eighteenth century that medicalised assessments began to appear with any regularity. Prior to this, the written evidence of medical practitioners was frequently indistinguishable from that of the rest of the populace. This is illustrated by the surgeon's report that accompanied the 1698 petition of Balthasar Herwig from Cörnbach in the district of Milsungen. Johann Michael Reinhardt, the local surgeon described Balthasar's condition thus: Governmental officials (*hochfurstl. Hhl. Beamten*) had sent Baltzer (sic) to the surgeon that day so that he could carry out an assessment of the invalid's condition. Reinhardt had 'inspected' the sufferer and discovered

[68] LWV, Bestand 17, Reskripte, 1716.

that 'the nerves on the upper right leg are quite withered [*gantz welck*] ... The normal balsam [*gewöhnlichen lebens balsalm*] that [Balthasar used] for this was no longer healing [the affliction]'. As a result, the leg had 'dwindled away ... and [in Reinhardt's opinion] must eventually [become] quite withered and corrupted [*verderben*]'. In short, the surgeon concluded, it was not possible to cure or in any way aid this injury.[69]

The report of the officials from Milsungen offered some interesting additional information regarding Balthasar's condition – which they described variously as 'lameness', 'bodily indisposition' (*zugestoßene Leibs unpäslichkeit*) and 'frailty' (*gebrechlichkeit*). It was noted that the invalid was twenty-five year of age and that he had already suffered this injury for two years. In the intervening period he had searched everywhere for every possible cure. It would appear, however, that 'the lameness, ... having taken root', was impossible to reverse.

In the majority of cases, the degree of medical information imparted depended to a large extent upon the individual author. Some correspondence from officials explicitly stated that the attending medic had not wished to write a separate report, but had requested that his comments be added to the official's testimony.[70] This occurred throughout the period. Even in mid- to late-eighteenth century cases (that is, after the ordinance of 1728), minimalist diagnoses were offered. In Johannes Landau's petition of 1738, the surgeon, Johannes Orth, merely reiterated all that had been said in the previous correspondence, namely that the individual was old and had a badly broken leg.[71]

In comparison, however, much more detail was offered in some earlier reports – indicating once again that 1728 can not be taken as a date that indicated the commencement of medical diagnosis. A 1715 petition included a fairly extensive joint comment from a local doctor and surgeon (David Schreiber, *Physician Ordinarius* and Andres Engel, surgeon). It is useful to look at this document in full. Elisabeth Möhrgen, the twenty-two year old step-daughter of Christian

[69] LWV, Bestand 13, Reskripte, 1698.
[70] See, for instance, LWV, Bestand 13, Reskripte, 1721 (Niclas Göbels).
[71] StAM, Bestand 229I, Reskripte, Haina, 1739.

Scheffels, had requested the surgeon and physician to write her a report, detailing her medical condition so that it could be sent as part of her petition. The practitioners reported that, after 'sufficient exploration', they had found that Elisabeth had suffered from 'great pain in the right foot (*Huffs*) and *circa nates*'. Her right knee was also swollen, meaning that she was forced 'to suffer day and night'. The medics further reported 'that she cannot move this same joint'. The 'pain in [her] right [leg] has increased to the extent that she is unable to do anything other than lie on her stomach, her head and legs hanging out of bed'. During the day she needed to use a crutch. A year previously Elisabeth had 'laboured with a tumour (*tumore erysipelatoso*) in her leg'. The surgeon had been unable to cure this condition and apparently also failed to stop it becoming ulcerated. As a result of this, her tibia and fibula (*mulieris tibiae & fibula*) were covered in distinctive 'scurvy ulcers' (*ulcera scorbutica*). When the latter were opened, the patient received relief from the pain in her *tibiae*. In sum, however, Elisabeth was 'suffering great pain'.

The practitioners considered 'this affectum to be a *malum ischiaticum ad paralyticam constitutionem inclinans*, or lame arthritic-flux [*Gicht*] in the foot'. Although this was a *malum pertinax*, it 'is however often cured through great diligence, effect and continued use of expedient medicines'. The surgeon and doctor decided that 'because this person's poverty is so large', she was impeded from using the required methods. She had, moreover, already suffered from this condition for three years. It was therefore believed that a complete cure could not be effected. The report ended with the comment that 'although through much effort and expense the pain would be alleviated, [there could be] no lasting relief for this pauper'.

Consultation of medical practitioners also occurred in earlier periods. In 1698, for instance, Anna Catherina Spanaus from Elgershausen, in the district of Kassel, petitioned Landgrave Carl to be allowed into Merxhausen. Her request stemmed from her 'physical infirmity' (*leibs gebrechlichkeit*). In her letter, Anna recounted how, 'quite by chance' she had suffered a flux (*Fluß*) in her arm that had rendered her incapable of both working and supporting herself any longer. The report of the surgeon, Gerhard Henrich Reinhardt, offered further details. He

explained that he had been ordered by the mayor to visit the applicant, and to make his report. He described Anna as suffering greatly from the condition that afflicted her arms and legs. He had also found holes in both thighs which were full of 'vile dampness [*vüsteriger feuchtigkeit*]', and which obviously caused much discomfort. In the surgeon's opinion, the patient was suffering from scurvy and arthritis.

An interesting comparison can be found in a 1699 petition concerning Anna Elisabeth Geitzemauerin, a 44 year-old, blind woman. Dr. Schade, the *Physician ordinarius*, (who was also the hospital physician for Merxhausen) wrote in his report of 3rd. February 1699 (from Homberg) that following her petition, the applicant had been brought to the house of the treasurer (*Rentmeister*) so that the doctor could examine her sight and her body and question her about her infirmities. The physician noted that the applicant was suffering from a glassiness/fixedness (*stahr*) and a mucous (*schleimigen*) and glutinous (*zähen*) dampness in both eyes. It would appear that at the present time this condition was relatively stable. Nevertheless, the doctor warned, the situation could quickly change and render the patient blind. Upon commenting on her eye problems, Dr. Schade also noted that her condition was, theoretically at least, curable although this would be very difficult to effect. As well as using some form of 'external medicines' (which, at best, would only work slowly because of the extent of the dampness), it was also deemed useful to incorporate some other form of (unfortunately unspecified) medicine (*artzneÿen*) and also a change of diet. This would not only be helpful in the attempt to restore her sight, but it 'could also remedy the additional ailments (*den übrigen zufällen*), such as narrow-chestedness, painful limbs, arthritis / gout [*Gicht*] and other scurvy conditions'. The doctor concluded, however, by adding that the patient and her father had already tried all such remedies without success.[72]

Continuities are also evident in some later eighteenth century correspondence. This is illustrated by the 1743 report of Bernhard Pfankuch, the physician of Haina and Merxhausen, regarding the application of a 'single farmer' Friedrich

[72] LWV, Bestand 17, Reskripte, 1699.

Ledholtz from Röhrshain in the district of Ziegenhain. This document is particularly interesting for comparative purposes. Whereas the correspondence relating to Elisabeth Scheffels contained many Latin references, this much later source offers no such information. Such an omission reminds us that we should not merely assume that documents from the eighteenth-century onwards would be more 'medicalised'.[73] Ledholtz had visited Dr. Pfankuch and requested that his 'frail physical constitution' be examined so that the physician could write him a testimony. Pfankuch writes that this 'person appears to be fifty years of age, and seems ... according to external appearance to be of good stature'. He had however suffered from 'a thick hard leg [*dick-hart bein*]' and prior to this had also 'laboured under a lengthy fever'. This had confined him to bed – an act that was 'not without great cost to himself'. Ledholtz's medical history could (according to Pfankuch) be attested to by the community of Röhrsain, suggesting perhaps that the doctor had spoken to these people. The applicant's 'health and bodily strength had suffered so much damage', that his condition had changed constantly over time. Fatigue and other infirmities had now rendered him incapable of all forms of work. He was also plagued with the early stages of catarrh (*affectus catarrhalis*), which the doctor believed would worsen in time. Ledholtz had also offered a payment of fifty *Reichsthaler* if he were accepted into Haina.[74]

Further comparative research is required to ascertain whether one can distinguish between diagnoses made for a variety of physical illnesses, or indeed whether differences existed between the reporting of mental and physical conditions. Would we, for example, obtain a more detailed commentary regarding a person who was suffering from some from of rheumatism than we would for a blind individual? If so, how can we explain this? Does it relate to the medical knowledge of the time (or of the individual practitioner), or does it relate to the visibility of certain conditions? Did seemingly 'obvious' afflictions, such as blindness, receive minimal space within reports whereas 'inner diseases' were

[73] This can be compared to the findings of Francisca Loetz relating to nineteenth-century medical practitioners. (Idem, Vom Kranke zum Patienten: "Medikalisierung" und medizinische Vergesellschaftung am Beispiel Badens, 1750 – 1850, Medizin, Gesellschaft und Geschichte, Beiheft 2. Stuttgart, 1993.)

[74] LWV, Bestand 13, Reskripte, 1743.

allocated more attention? Can we identify a class distinction? If we looked at cases of doctors attending individual private patients, would lengthier notes and explanations be offered for them while the poor would receive at most a few brief sentences? Such issues must remain questions until more extensive work has been undertaken. It is nevertheless worth bearing such ideas in mind when reading the pauper petitions.

Prior to the late eighteenth century medical comment within the application process varied widely. Nevertheless, its existence counters the claims of Erik Midelfort that 'the authors of these hospital documents had no interest in medical diagnosis; their only intention was to demonstrate that a person needed care and no professional diagnosis was necessary for that'.[75] One of the most prevalent themes throughout the whole early modern period (and beyond) relates to the costs of medical treatment that the supplicant had used prior to requesting to enter the hospital. This is perhaps unsurprising when we consider that one of the primary prerequisites for acceptance – if one was under sixty years of age – was that one's ailment was incurable. As will become increasingly evident in the following chapters, these individuals had often laboured under an illness for quite some time prior to applying for hospitalisation. References to unlicensed cures do not appear in any of the petitions under consideration here. This omission mirrors the general European-wide movement against such practices in this period. (However as will be shown below, records reveal the employment of unlicensed practitioners within the territorial hospitals, at least in the sixteenth- and seventeenth centuries.)

[75] Midelfort, Madness, pp. 358 - 359. Although Midelfort's article concentrates predominantly upon the sixteenth century, his work also includes later examples.

ii. Impoverishment and the medical market-place.

A common theme throughout many of the petitions is that the individual and their family have invested a considerable amount of money in medicines in the hope of finding a cure. As has already been revealed in the case of Elisabeth Scheffels, the petitions reveal that, prior to application, the afflicted had unsuccessfully consulted many medical practitioners.[76] The costs were often not inconsiderable. A 1754 report from a woman in Schmalkalden recorded a payment of two hundred *Reichsthaler* for a seven-month treatment prior to a request being made for hospitalisation.[77] Sometimes this expense was specifically attributed to the impoverishment of the applicant. Thus in 1696, Johannes Möller, from Wickersdorff in the district of Lichtenau, mentioned in his petition for Haina that due to his 'unhealthy limbs' and other infirmities, he had increasingly been forced to use his assets to pay for the doctor's fees (*artzlohn*).[78] This is a universal theme that seems to transcend time. Neither were the *Landesspitäler* employees exempt from such worries. In 1730, for example, Bernhard Dircking, the Haina forester, petitioned for his ten year-old son to be received into the hospital. He wrote, 'more's the pity, a great misfortune has befallen me'. Namely that 'through the feverish and evil infant smallpox [*durch die hitzigen und böβen Kinder=blattern*] the sight of my ten year old son has been damaged [*seines Gesichts beraubt*] and [he] has become blind'. Bernhard noted that 'out of fatherly duty' and 'in accordance with [his] limited means', he had searched for a cure for his son. All attempts had not made even the slightest improvement. As he explained: 'on the contrary, I have as a result only been set further in poverty'. He also had his wife and his remaining, small (*ohnerzogenen*) children to consider. Regarding the family's impoverished status, he lamented: 'as a result of [my] very low pay, [I] do not know how to reverse the situation...'[79]

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[76] See, for example, LWV, Bestand 13, Reskripte, 1702 (Adam Krug).
[77] Cited in Vanja, 'Leid', pp. 223 – 224. No further details are given.
[78] LWV, Bestand 13, Reskripte, 1696.
[79] Ibid, 1730.

Many of the applicants had laboured under their afflictions for many years prior to requesting hospitalisation. In her 1706 petition to Haina, for example, Maria Catharina Krugin, widow of the pastor from Großen Zimmern, recorded that she and her late husband had spent the past decade searching for a cure for their epileptic and raving mad (*tobsüchtige*) son. They had used their 'limited means' to search 'far and wide' for the elusive medicine that might cure their offspring. All efforts had failed.

The documentation frequently mentions earlier, short-lived cures whereby an individual appeared to have overcome their illness, only to be struck down by it again at a later date. (The importance of the 'appearance' of good health or sickness is a prevalent theme to which I will return at various points in this thesis.) We learn, for instance, of the plight of Elschen, the widow of Drußen Aldehens from the town of Frankenberg.[80] In the previous year, Elschen had become 'quite frail in the head'. By the grace of God, she had recovered from this illness. Over the course of time, she had been struck by misfortune once again, and had become 'quite frail and without reason [*sÿnloß*]'. Such 'cures' were most frequently associated with mental illnesses. This may be due to the nature of these afflictions and also to the fact that the workings of such conditions were largely internal and only displayed their outward manifestations in a person's behaviour. In the case of physical illnesses, the onlooker would have usually been able to see whether or not an ailment was healing.

iii. Medical treatment in the territorial hospitals.

A fully detailed analysis of medical treatment within Haina and Merxhausen is not within the confines of this thesis. One of the main foci of these institutions was doubtless the care afforded to patients suffering from chronic conditions in

[80] LWV, Bestand 17, Reskripte, 1579. This is one of the earliest surviving cases of an urban resident applying for entry into Merxhausen. Interestingly enough, Landgrave Ludwig's acceptance letter makes no mention of the fact that Elschen comes from a town, but states that she should be accepted and kept 'as other poor nonsensical persons (*sinloß*)', until such time as she recovers.

terms of the provision of food, shelter, and spiritual solace.[81] Medicine did however play an important part in hospital life, as is evidenced from the employment of doctors and barber-surgeons – although admittedly, for most of the period under consideration here, these men lived outside the institutions. We will now consider some of the main features of hospital medical practice that have either been incorrectly commented upon, or have been either largely or completely ignored within studies to date.

In his publications regarding the formative years of Haina, Erik Midelfort has denied the existence of medical practice in the hospital. His statements include the fact that the institution was 'not medical in its purpose or inspiration' and that it 'had no regular physician for the first 200 years'.[82] Not only are such assertions false, but they are particularly interesting considering that one of Midelfort's prime arguments in at least one of his studies lies upon the Haina as a 'Protestant monastery', and he stresses the continuity between pre- and post-secularisation practice. In line with other medieval monasteries, Haina had long offered some form of medical care.[83] The earliest reference to its infirmary has been found in a document dating from February 1st, 1270.[84] This medical heritage continued and expanded after the secularisation of the monastery in 1527. This is best illustrated in the figures of Johann Dexbach and Johann Hundsdorf. Respectively the cellarer (*Kellner*) and bursar (*Bursarius*) of the former monastery, they decided in 1527 to remain in the institution and worked in the newly-founded hospital in the prestigious roles of governor (*Pater*) and treasurer (*Rentmeister*). As will be discussed in due course, it would appear that Dexbach also continued his monastic role as the institution's doctor. The latter occurrence finds its counterpart in the *Heiliggeist-Hospital* in Reformation

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[81] For a detailed discussion of the provision of food, see Schlieper, 'Ernährung'.

[82] Midelfort, H. C. Erik, 'Madness and the Problems of Psychological History in the Sixteenth Century', Sixteenth Century Journal, No. 1, 1981, pp. 5 – 12, here p. 8; also, Idem, Madness, pp. 358 – 359.

[83] See for example Knefelkamp, 'Städtische', pp. 53 – 54; Conrad, Lawrence et al, The Western Medical Tradition 800 BC to AD 1800, Cambridge, 1996, p. 148.

[84] Franz, E. G., Haina, 1, Nr. 546 (Leinenzeugstiftung für das Dormitorium, den Schlafsaal der Mönche); Siefert, Helmut, Kloster und Hospital Haina. Eine medizinhistorische Skizze, Sonderdruck aus Hessisches Ärtzeblatt, Jahrgang 32, Heft 11, November 1971. Regarding the infirmary see also Jetter, Dieter, Geschichte des Hospitals Band 1, Wiesbaden, 1966, pp. 11–21; Leistow, Hospitalbauten in Europa aus 10 Jahrhunderten, Ingelheim, 1967, pp. 17 – 24. For a

Copenhagen. Here too, the monks and the prior remained in the hospital after the Reformation and became attendants to the sick (*Krankenpfleger*) and, in the case of the prior, the governor (*Vorsteher*) of the establishment, working under the personal protection of the King.[85] Similarly, in Ulm many of the nursing sisters converted to Protestantism and continued their care work.[86] We should therefore be wary of assuming that the Reformation must equate with a wholly new system of medicine. Rather, it would appear that in Hesse at least, existing structures were improved and previously religious-based enterprises were secularised. Crucially, at the onset of this religious movement, the personnel (and in many respects their caritative motivations) remained largely the same. We should not blithely assume, as Midelfort would appear to have done, that a monastic history (or indeed framework) implies a lack of medical provision. As many historical works have amply demonstrated, these were the very institutions that had supplied the majority of medical care for the rural populace.[87]

It is true that the origin of the territorial hospitals was not 'medical in its purpose' in the same way in which modern institutions are today. Nor indeed, did the patients hold the specific clinical interest that was a feature of the later eighteenth century teaching hospitals.[88] Neither can we compare them to the early modern *Blatternhäuser*, established to treat those suffering from syphilis. These hospitals were founded to offer long-term care to the chronically ill. Nevertheless, medicine also had to play a role from the outset – even if it were merely a case of managing an individual's pre-existing condition.

Even in the *Landesspitäler*'s formative years, at least some members of the hospital administration had some knowledge of medical terminology. Following its secularisation, one of the former Haina monks, Johannes Dexbach, remained

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later period, see Nolte, Rüdiger, Pietas und Pauperes. Klösterliche Armen-, Kranken- und Irrenpflege im 18. und 19. Jahrhundert, Weimar, Köln & Wien, 1996.

[85] Thomasen, Anne-Liese, 'Das Wechselvolle Geschick des Heiliggeist-Hospitals in Kopenhagen', Historia Hospitalium. Zeitschrift der Deutschen Gesellschaft für Krankenhausgeschichte, 1981 – 1982, Heft 14, pp. 35 – 55, here p. 46.

[86] Schulz, Ilse, Schwestern, Beginen, Meisterinnen: Hygieias christliche Töchter im Gesundheitswesen einer Stadt: ein Beitrag zur Geschichte der Pflege und Heilkunde, Ulm, 1992, pp. 60, 70.

[87] For a brief summary, see Wolff, Geschichte, pp. 82 – 91.

[88] For a brief summary, see Risse, Mending, pp. 217 – 246.

in the institution and continued (and no doubt expanded) the medical roles that he had undertaken as the monastic doctor. In comparison, in a 1574 evaluation of the Haina inmates the Latin terms have been added to the few conditions mentioned. Presumably the work of the pastor, it includes the translation of 'epilepsy' into '*morbo caduco*' and '*mondsüchtiger*' into '*lunaticus*'.[89] This is a rare occurrence. Much more common is the list of 1586 that details, among other things, an individual's medical condition using vernacular terminology.[90]

Medicine played a role in hospital life from the outset. The first specific accounts relating to medicine that I have unearthed stem from 1585. The Merxhausen *Jahrsrechnungen* allocate a specific section for the 'Expenditure of money for medicines and the salary of medical practitioners [*Artzney und Artzlohn*] [which has] been used on the poor'.[91] The sum total amounted to twenty-three *gulden*, five *albus* and six *heller*. Admittedly, this record does not offer us much detail regarding specific remedies. Nevertheless, it allows an insight into a level of medical practice within these hospitals which was to follow a similar pattern throughout the period under consideration in this thesis. Moreover, it proves incorrect the aforementioned assertion of Midelfort. We learn, for instance, that three *gulden* and fifteen *albus* had been spent upon goods that the clerk (*Haußschreiber*) from Hofheim had purchased for the hospital at the Frankfurt Lent fair (*Fastenmeeß*). These included measures of both the 'best' and the 'worst' theriac (two *loth* of each) and also a quantity of 'tree oil' (*Baum Oley*). Interestingly enough, payment was also made to an unlicensed practitioner, listed as 'the wife of Churt [sic] Abels from Lohna' who was paid two *gulden* and eight *albus* for healing two sisters from Franckenau and a mute from Frankenberg (presumably all hospital inmates). Other listed medication included five *albus* paid to a certain Eÿla Stoßin, a 'sister' of Merxhausen who, upon the request of hospital officials, had provided 'a quantity [*Merzen*] of juniper berries. By far the largest sum, however (ten *gulden*, fourteen *albus* and six *heller)* was spent 'upon medicines in this ... year by the apothecary, Cornelius Stoßen from

[89] German transcription in Demandt, 'Hohen', pp. 96 – 98.
[90] Ibid, pp. 114 – 132.
[91] Regarding *Rechnungsbücher* as a source, see Jantz, Gerhard, 'Klösterliche Rechnungsbücher als Quelle für der Medizin in monastischen Gemeinschaften des Spätmittelalters. Methodische,

Kassel for the aid of the poor and particularly in this time of pestilence'. (Erik Midelfort has noted a departure rate of 24.6 per cent among the Merxhausen patients in Merxhausen during 1585. It may well be that this was due to some form of pestilence - we know that in 1597 fifty-six out of the staggering sixty-seven persons who died that year, were recorded as dying of 'pestilence'.)[92] The remaining six *gulden* and fifteen *albus* was spent upon medical practitioners of various types. The largest sum, four *gulden*, was earned by Meister Valtter Sÿgmundt, a surgeon (*Wundarzt*) from the neighbouring town of Gemunden. In 1585, Sÿgmundt had visited the hospital every three weeks, administering baths and letting blood. He was paid a further one *gulden* and five *heller* for dressing the wounds of the poor and applying lotions (*Salbe*).[93]

We are fortunate to have a comparable surviving account for Haina for the same year. Contrary to the assumption that women would have fared worse than the men in the treatment that they were given, the 1585 records reveal that Merxhausen spent more on medicines in that year than Haina. The sum total for the latter is seventeen *gulden*, twenty-three *albus* and seven and a half *heller* (compared to twenty-three *gulden*, five *albus* and six *heller* for Merxhausen). Most of this Haina expenditure went to two apothecaries in Marburg (Peter Grauen and Matheo Schrödern) for a variety of purchases. On one occasion, Peter was paid three *albus* and three *heller* for camphor and 'white wax' which had been bought for medical use. The remaining payments of three *gulden*, one *albus* and seven-and-a-half *heller* and two *gulden*, twenty-five *albus* and four-and-a-half *heller* covered purchases made at the Easter and autumn fairs (*Ostermeß und Herbstmeß*).[94] One interesting omission – which may explain the higher total expenditure in Merxhausen – relates to medical practitioners. With the exception of the barber-surgeon who was paid for his services at the autumn fair (presumably for medicines that he purchased), no other reference is given to these professions. It may well be that, in this year, the Merxhausen expenses covered the practitioners' visits to both hospitals – if so, this is contrary to later

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quellenkritische und inhaltliche Überlegungen', in Medizin, Gesellschaft und Geschichte, Band 9, Institut für Geschichte der Medizin der Robert Bosch Stiftung, 1993, pp. 80 – 93.

[92] Midelfort, 'Protestant', p. 88.

[93] StAM, Bestand 229I, Jahrrechnungen, 1585.

[94] PKH, Bestand 13, Hospitals Geld-Rechnung (Haina), 1585.

years, during which the opposite scenario occurred. Similarly, in comparison to the Merxhausen accounts, no mention is made of plague or 'pestilence'.

Many of the medicines utilised seem to have remained similar throughout the period under consideration here. The 1690 yearly accounts from Merxhausen, for example, include the purchase of plasters, powder for the flux, theriac, and spirits.[95] In addition, the *Jahrsrechnungen* reveal that, throughout the period, surgeons utilised a variety of medicines including *Simplicia* and *Composita*, and herbal remedies. Chemical preparations were also implemented which were designed to purge the body and also to calm it and to alleviate pain. The treatment of external wounds also featured. Reliance on age-old methods is not unique to practice within the *Landesspitäler*. In his study of eighteenth century Edinburgh, Guenter Risse discovered that approximately two-thirds of the cases treated by the Infirmary used purgatives.[96]

Viewed as a whole, the amount spent upon medicines and medical care was minimal in comparison to that expended on other items – in particular food.[97] In the Merxhausen accounts from 1701, for example, 40*R* is entered as the monies given to medicine (*Ärtzeney*) during that year. This can be compared to the 30*R* that covered the advocates' fees (*Advocaten gebühr*) and the 35*R* that had been spent on shoe soles.[98]

One of the main problems regarding this type of source concerns both the cause of the treatments and the lack of specific information regarding their implementation. It is usually unclear whether an individual was receiving medical aid as a result of the pre-existing condition that brought him or her into

[95] StAM, Bestand 229I, Rechnungen – Belege, 1690.
[96] Risse, Guenter B., 'Hospital History. New Sources and Methods', in Porter, Roy & Wear, Andrew (ed.), Problems and Methods in the History of Medicine, London, New York & Sydney, 1987, pp. 175 – 203, here p. 193.
[97] Regarding the importance of food in the hospitals see Schlieper, 'Ernahrung'. It is useful to note the continuance of this trend. Regarding Enlightenment Britain, for instance, Guenter Risse has argued that 'diet was still the first line of therapy in hospitals'. In Risse, Mending, p. 246. Compare to Conrad et al, Western, p. 148 (concerning the small amount of money spent upon medicines in comparison to other costs.); Jütte, Robert, 'Die "Küche der Armen" in der Frühen Neuzeit am Beispiel von Armenspeisungen in deutschen und westeuropäischen Städten', Tel Aviver Jahrbuch für deutsche Geschichte, XVI, 1987, pp. 24 – 47.
[98] StAM, Bestand 17I, Nr. 2282.

the hospital in the first place, or whether it was a purely reactionary measure to an isolated event, such as a new injury that had been sustained. How are we to account, for example, for the treatment given to Eüla from Ober Zwehren in 1691? Eüla was given some form of drink that was designed to induce sweating (*Schwitztranck*) and a powder for the flux (*Fluß pulver*) as a remedy for her 'thick' and swollen legs.[99]

In some cases it would appear the medicines related to new conditions. The 1691 Merxhausen accounts from the barber surgeon of Naumburg, Adam Adelli, for instance, included a reference to 'big Anna' who had fallen on one knee and had badly damaged her kneecap. She was administered with creams and plasters (*Pflaster*) until she had been cured. This treatment cost a total of twenty-six *albus* – the second largest single cost in the entire receipt for that year. Similarly, one of the sisters from Upper Vilmar was treated with a plaster after she suffered a 'severe injury'. It also appears that the hospital was affected in some measure by 'red dysentery' (*Rothen ruhr*) in this year. References abound to drinks and powders being given to counter the effects of this illness – recipients included Anna Catharina from Schönstatt, Anna Maria from Wolfhagen, Anna Gerdraut from Schonstatt and Gehla, the 'old servant'.[100]

Given that the *Hospitaliten*'s conditions were chronic, it seems most likely that, for the majority of the cases, the assistance offered related to short-term measures rather than lengthy programmes designed to offer cures – although the latter were also sought after. While rare, 'cures' did exist, although the exact early modern understanding of this word is unclear. In 1599 for instance, the surgeon Henniges Bärneman was paid seven *gulden* and ten *albus* for curing Elßgen, 'a hospital person', of a 'fluid' (*flussig*) and 'incurable thigh'.[101] As will be illustrated throughout this thesis, instances did occur in which patients left the hospital, believing themselves to be sufficiently 'cured' to be able to support themselves in the outside world.

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[99] StAM, Bestand 229I, Rechnungen. Belege 1687 – 1697.

[1] Ibid, Rechnungen-Belege, 1687 – 1697.

iv. The appointment of medical practitioners

We have shown that a variety of forms of medical care were available to the inmates within the territorial hospitals. What of the medical practitioners themselves? How were they appointed? While not providing the full story, the following examples offer interesting indications regarding both the understanding of the term 'medical practitioner' and of the importance placed, when employing such a person, upon medical prowess as set against other factors such as hospital politics, state policy, and patronage.

Perhaps the most obvious point at which care is evident lies within the duties of the attendants. These 'overseers' (*Aufwärter*) were married couples who lived in the building for which they were responsible. As was the policy for their charges, upon their death, all of their property (which was normally non-existent) was to revert to the institutions. Up until 1728, these persons had to be childless. After this date, they were allowed offspring as long as their family was neither too large (and thus a drain on hospital resources), nor contained small children (whose demands would distract their parents from their work). They were distributed throughout the various buildings and rooms in the establishment which held inmates. For instance, in Haina in 1700, two attendants (an 'overseer' and his wife) were employed in each of the following rooms: the 'sick room', the *Kapitel* [sic], the upper floor of the *Blockhaus*, the lower floor of the same building, and the 'large room'. Ten attendants were thus supplied for a population of one hundred and forty-eight incapacitated residents.[102] They received assistance from those patients who were capable of helping Salaries for the men were consistently almost double that of the women attendants. In the seventeenth century, the females were paid a yearly wage of one *Cammergulden* and one pair of shoes. This doubled in the early eighteenth century.[103] By contrast, in 1713 and 1715 Martin Ritter, an attendant of the sick (*Krankendiener*) earned five *Cammergulden*, twelve *Ellen* of linen cloth and two

[1 1] Ibid, Rechnungen – Belege, 1599. Regarding the ambiguity of the term 'cured', see Risse, 'Hospital', p. 184.
[102] StAM, Bestand 17I, Nr. 2195.
[103] See for examples, StAM, Bestand 229I, Rechnungen – Belege, 1670.

pairs of shoes.[104] In addition to their caritative duties, it would appear that the *Aufwärter* were also responsible for distributing medicines, thus suggesting at least a rudimentary knowledge of such practices. The 1694 furniture inventory for Merxhausen lists within the room of a certain Stoffell, one of the attendants, 'a small brass spoon' which the poor used to take their medicines.[105]

Qualified practitioners were also enlisted from outside the hospital.[106] Records reveal quarterly visits by a doctor. In the early eighteenth century for instance, Dr. Bernhard Pfannkuch attended the sick in both Haina and Merxhausen in January, April, September and November. He received a payment of three *Cammergulden* for each visit. The hospital accounts also record the presence of a barber surgeon (*Bader*) who bathed the inmates, cut their hair and also performed bleedings (*Aderlassen*). In 1715, for instance, Johann Henrich Schneider from Felsberg received payment of 3 quarters (*Viertel*) of corn, one pair of shoes and five *Cammergulden* for performing these duties in Merxhausen. (His name still appears in the 1739 records.) The hospital also employed another barber surgeon (*Barbirer*) who seems to have been responsible for actual surgical practice. From at least 1630, a barber surgeon would visit the hospitals once a week.[107]

According to Holthausen, a surgeon was resident in Haina from 1703. All surgeons had to have completed a four-year apprenticeship with a surgeon who was recognised by the *Collegium Medicum* in Kassel.[108] These practitioners were, in the first instance, meant to treat the external injuries of their charges under the supervision of the hospital doctor. Holthausen argues, however, that in reality these individuals frequently overstepped these guidelines and were seldom brought under the control of the hospital physicians.[109] This can presumably be explained by the fact that they visited the hospital more regularly

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[104] StAM, Bestand 229I, Rechnungen – Belege, 1713 – 1716. According to Schlieper, 1 *Elle* = 57.04cm. Schlieper, 'Ernährung', p. 218.
[105] StAM, Bestand 17I, Paket 1.
[106] Regarding the lack of permanent staff in the *Landesspitäler*, compare to Rawcliffe, 'Medieval', p. 9.
[107] Wickel, Carl, "Landeshopsital', jetzt Landesheilanstalt Haina (Kloster), 400 Jahre', in Geisteskrankenpflege, 37. Jahrgang, Heft Nr. 9, September 1933, pp. 129 – 144, here p. 138. See also StAM, Bestand 229I BIIb Specialia, Paket 4, (B – M), '1699 Instructionen – Johann Friedrich Möller'.
[108] Grebe, 'Chirurgen', p. 282.
[109] Holthausen, Landeshospital, p. 53.

than the doctors (at least once a week) and thus had more frequent contact with the patients. The Merxhausen surgeons came from the neighbouring region – for instance, from Naumburg, Wolfhagen, and Gudensberg. In the hospital accounts of 1715, *Barbirer* Moller (also Müller) was paid thirty-six *Cammergulden* and twenty-four *albus* for the medicines that he had purchased. (The hospitals usually employed both a *Barbirer* and a *Bader.*) His annual salary was four quarters of corn, one pair of shoes and three *Cammergulden.* In 1739 this had risen to sixteen quarters of corn, two bundles (*Claffer*) of wood, one pair of shoes and five *Cammergulden.*[110] The Merxhausen surgeons had access to their own rooms within the hospital that included the apothecary. With every hospital visit these practitioners would receive an extra payment of one *Maß* of wine or beer, two cheeses or herrings and a small portion of bread.[111] The last appointed practitioner who appears regularly in the accounts is the apothecary – in the 1715 and 1725 Merxhausen accounts these individuals come from Gudensberg and Kassel. [112]

The first external doctor to be appointed to the territorial hospitals was Johannes Dryander. The son of the prestigious Marburg professor of the same name, the younger Johannes was commissioned to work as a doctor for the poor in Haina and Merxhausen.[113] According to his contract, he was to diligently visit the poor and infirm inmates, caring for them in times of illness and endeavouring to cure their ailments to the best of his ability. To make his job easier, he was instructed to reside in neighbouring Treyßa. As payment, Dryander was to receive from the Haina governor a yearly salary of one hundred *gulden* and an additional twenty 'quarters' [*Viertel*] of oats for his horse (which he required for transportation between the two institutions). He was also paid eight 'quarters' of corn and four bundles of wood.[114] Further correspondence from Landgraves Wilhelm and Ludwig stated that Dryander should be provided with everything that he

[110] StAM, Bestand 229I, Jahrs-Rechnungen De anno 1715 und 1739.
[111] Grebe, 'Chirurgen', p. 282.
[112] StAM, Bestand 229I, Merxhaußer Jahrs-Rechnungen De anno 1715 und 1725.
[113] Dryander Senior (1500 –1560) was Professor of Mathematics and Medicine at Marburg University. He carried out some of the first public dissections in Germany in 1534, 1536 and 1539. This interest was incorporated into his two anatomical works *Anatomia Capitis Humani* (The Anatomy of the Human Head) published in 1536, and *Anatomia Hoc Est Corporis Humani Dissectio* (Anatomy. That is the Dissection of the Human Body) which appeared in 1537.
[114] Demandt, 'Hohen', p. 100; StAM, Bestand 17I, Nr 652.

required. This related in particular to some form of rooms (*Losament*) within Haina where Dryander would be able to make his preparations (such as *gebrandt waßer*). To this end, he was also to be given all of the instruments necessary for him to carry out his work.[115]

The 1587 financial records from Haina provide greater detail regarding a wider variety of practitioners who were employed in some capacity by the hospital. The total expenditure in this year – forty-eight *gulden*, forty-three *albus* and nine *heller* - was significantly higher than two years previously. This increase is explicable by the inclusion of payments for medical treatment. (Expenditure upon the materials themselves is roughly comparable to 1585.) Purchases were made at the Lent and the Frankfurt fairs. These included payments for tree oil (*Baumoleÿ*), bay leaves (*Lorbern*), Venetian soap, scissors for cutting hair and something (*Bueechßlein* - some form of container?) relating to mercury (*Quecksilber*). It is also clear that a wider variety of practitioners were consulted than we would perhaps expect – and indeed than occurred in later years. For example, six *gulden* was paid to Master Abraham, the 'syphilis doctor' (*Frantzosenarzt*) from Frankenberg who had healed one of the hospital brothers – details as to either the identity of the latter or to the specific treatment used are, unfortunately omitted.[116] Similarly, one *gulden* was paid to 'Gabriel', a doctor from Römerhaußen, who had healed one of the 'brothers'. A further six *gulden* and six *albus* were paid to a doctor in Frankfurt. Among other medical services he had also cured one of the brothers, a certain Hannßen Steubern, of his 'weakness' (*schwachheit*). The list reveals that this patient had received other treatment that year. Master George, a surgeon (*Wundarzt*) from Frankfurt was paid two *gulden* and two *albus* for letting Steubern's blood and applying cool plasters (*khuel Pflastern*) during his 'weakness'. The use of the term 'weakness' is particularly interesting as it contradicts Midelfort's assertions that words such as *'schwachheit'* were deliberately vague terms, 'used to convey a general mental or physical debility without insulting the proud sensibilities of a duke or a duchess'. A consultation of these documents and indeed of contemporary

[115] StAM, Bestand 17I, Nr. 657b.
[116] Regarding this medical practitioner, see Jütte, Robert, 'Syphilis and Confinement: Hospitals in Early Modern Germany', in Finzsch & Jütte (eds.), Institutions, pp. 97 – 115, here p. 105.

lexicons reveals that the word *'schwachheit'* had a specific meaning related to ideas of 'weakness'.[117]

Of perhaps the greatest interest are the payments – significantly lower in value - made to practitioners who were clearly unlicensed. In 1587, eighteen *albus* was paid to a woman from Hawern [Habern?] who healed a youth from a condition that was vaguely described as *'den bösen grundt'*. A further seven *albus* was paid to one of the (unnamed) inmates for the medicines that he had purchased from the executioner in Wildungen, and which he had used to treat a patient's problems with their feet (*bösen fus*).[118] In 1599, Timothao Abell, the pastor from Wellen received ten *albus* for preparing a drink for Barben from Treiß (Treyßa?) for her 'weakness in the head'. Neither was this practice limited to the sixteenth century. In 1690, a certain Johann Knabellen from Lohna was paid for the medicines that he had provided for one of the sisters who was suffering from eye problems (*boßen Augen*). He had also administered a plaster to treat the ailing legs (*bosen beÿne*) of Anna Ursull from Grunberg. In total, Knabellen received ten *albus* and eight *heller* for this work.[119]

Those in charge of hospital administration were willing to make use of the medical prowess of their inmates in the name of the 'common good'. Neither was this provision simply restricted to medicine. As will be highlighted in Chapter Six, it was not uncommon for some inmates to continue (in some capacity) with their profession once they became *Hospitaliten*. Surviving documentation from Haina in 1651 provides a good illustration of this bureaucratic agenda. In this year, Geörge Schober, a incapacitated (*contract*) apothecary from Bohemia requested that he be granted a place in the hospital, in return for which he agreed to tend to the poor therein.[120] Coming from Bohemia, Schober was a 'foreigner'.

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[117] Midelfort, H. C. Erik, Mad Princes of Renaissance Germany, Virginia, 1994, p. 4. Concerning *schwachheit*, see Zedler, Lexicon, pp. 1754 – 1756.

[118] PKH, Bestand 13, Hospitals Geld-Rechnung , 1587. Regarding the medical role of executioners, see Nowosadtko, Jutta, 'Wer Leben nimmt, kann auch Leben geben – Scharfrichter und Wasenmeister als Heilkundige in der Frühen Neuzeit', Medizin, Gesellschaft und Geschichte, 12, 1993, pp. 43 – 74; Herzog, Markwart, 'Scharfrichterliche Medizin. Zu den Beziehungen zwischen Henker und Arzt, Schafott und Medizin', Medizinhistorisches Journal. Internationale Vierteljahresschrift für Wissenschaftsgeschichte, Band 29, 1994, pp. 309 – 332.

[119] StAM, Bestand 229I, Rechnungen – Belege, 1690.

[120] For an explanation of this word, see Zedler, Lexicon, p. 1136. Zedler suggests that this term is used for those persons whose limbs or hands and feet have in some way become bent or crooked

According to the terms of the foundation ordinance, his application was therefore ineligible. Landgrave Georg, however, decided that Schober's inclusion would be of such benefit to the poor within Haina, that he overrode all such restrictions and accepted the practitioner's petition.[121] The understanding and implementation of notions of 'foreign' and 'belonging' were fluid throughout the period under consideration in this thesis, especially when an issue of service was at play. The Landgraves manipulated these concepts of nationality and identity in a manner that enabled them, as they saw it, to benefit both the institutions, the inmates and, as will be seen in the case of military casualties, the state of Hesse as a whole.

Just as prospective patients were to be native Hessians, so too is the issue of nationality apparent within applications for the appointment of hospital surgeons. In 1694 Gottfriedt Schultz, the surgeon of Gudensberg, contacted Landgrave Carl and requested that, 'because the appointed surgeon in Merxhausen [at this time] is a foreigner', the Landgrave should revoke his appointment and replace him with Schultz, a 'native of Hesse' (*Landtskindt*). While expressing his desire to give the placement to a Hessian subject, Carl stated that he was insufficiently knowledgeable about the situation to reach a firm decision. He requested that enquiries were made, and a full report given. Unfortunately no further details regarding this case have to date been unearthed.[122]

Family connections also played a role in the appointment of the medical personnel of the territorial hospitals. In April 1696, Sebastian Asmus Boppo, the 'clerk of the community chests' (*Kastenschreiber*) from Kassel, wrote to Landgrave Carl requesting that his son (who was based in Gudensberg) be considered for employment as the Merxhausen surgeon: 'For it had been ordered that at all times a surgeon should be employed to cure the poor and the sick'. Carl was unsure as to the usual salary commissioned by this hospital practitioner, and requested that he be informed. Boppo's son had learnt his trade with the surgeon Gerhard Heinrich Reinhard in Kassel. Following this training, he had worked for

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as a result of arthritis or gout (*Gicht*), cramps and 'other illnesses'. The wide-ranging meaning of this expression is indicated in his comment that it also refers to a person who is lame or is incapable of ordinary work. 'In German, one says he is stooped and lame'.

[121] LWV, Reskripte, Haina, 1671.

[122] StAM, Bestand 229I, BIIb, Paket 1.

nine years, going 'abroad' (i.e. outside Hesse) 'now and again'. Once again the nationality card was played. In his letter to the hospital superintendent, Boppo requested that his son should be employed 'as a native (*Landeskind*) before any foreigners'. The June report of the senior administration in Haina clearly stated however that Merxhausen was currently served 'by a good surgeon from Naumburg [a town outside Hesse, situated in the neighbouring domain of Mainz]'. Despite being a non-Hessian, his conduct to date had been good, especially in comparison to 'the previous [surgeon] from Gudensberg [who] had to be got rid of as a result of his constant gluttony [and the accompanying] wicked and immoral conduct [*Conduite*] with the poor and infirm [*gebrechlichen*] females'. The officials running these institutions were (understandably) more concerned with the conduct and capabilities of their employees than with their nationality.

The Hessian government in Kassel viewed things differently however. In a letter from Landgrave Carl dated 21st September 1696, it stated that 'for the same 'service' [*Bedienung*] [they would] rather have keen [*feine*] skilled people from Hesse' than employ 'foreigners', especially Catholics. As the issue was undecided, it was advised that the situation should not be altered until the visitation commission arrived at Haina.[123]

From later documents it appears that Boppo's son was not employed after all, although the reasons for this are unclear. Correspondence from the *Obervorsteher* from July 1697 referred to the appointment of a 'surgeon Müller from Alsfeld' who was now resident in Gudensberg. Müller (also spelt Möller) seemingly replaced the 'Naumburger surgeon'.[124]

Documents dating from 13th July 1699 detail the instructions given to the hospital surgeon Johann Friedrich Möller. In spite of the date, it would appear that this was the same surgeon mentioned above. (A second letter, dating from 30th March 1698, states that Möller had also read through his duties in the

[123] Ibid; StAM, Bestand 5, Hessische Geheime Rat, Nr. 18302; also LWV, Bestand 13, Reskripte, 1696; Grebe, 'Chirurgi', pp. 283 - 284.
[124] Grebe, 'Chirurgi', p. 284.

presence of the superintendent on this day, perhaps suggesting that this was an annual ritual.) The 'instructions' offer a brief job description of the practitioner's duties. He should work diligently and was to examine and treat all injuries, ensuring that he improved the situation rather than causing additional harm. A surgeon should show due respect to both the superintendent of the hospitals and the hospital medic and he should treat 'the poor hospital persons who require his help with the foreknowledge of the governor, [a man to whom] he should also show due respect'. In short, the surgeon was to serve the 'high hospitals' to the best of his abilities – his manner with the 'poor sisters' should be 'modest'. He was 'willingly and faithfully' to assist the poor sick (*Armen Krancken*) who should be visited as often as was necessary. The minimum time-scale (barring emergencies) was a weekly visit. All medication that was required was to be specifically logged and was to be reported to the governor at all time. At the end of the year these accounts were to be sent to the hospital physician for a form of audit. In short, the 'surgeon experienced in medicine [*Artzneÿ*] whose talents God had endowed' should care for 'every patient' in accordance with the art of surgery. Müller had not only promised to undertake these things through a written and verbal affirmation, but had also made a promise to God to the same effect. For these services, the surgeon was to receive a yearly salary, as his predecessors had done. [125]

The term 'patient' should be noted here. It appears in the hospital records from at least the early seventeenth century, both in documents relating to medical practitioners (as will be shown below) and to the applicants themselves. In the petition of Volbert Hase from the town of Rotenburg, for example, he describes himself as a 'poor, sick patient'.[126] While the use of this word in petitions is relatively scarce it appears much earlier than medical historiography has commonly believed to be the case, the latter usually locating the use of this word at approximately 1800.[127]

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[125] StAM, Bestand 229I, BIIb, Paket 4.

[126] LWV, Bestand 13, Reskripte, 1605 – 1625. Unfortunately I have been able to find no surviving information regarding this individual which may explain his usage of the term 'patient'.

As the appointed hospital surgeon, Müller was obviously successful in his job for he remained there until his death. The repercussions of his demise and the way in which the hospital went about finding a replacement offer insight into institutional politics and the importance of medical proficiency in the appointment of hospital staff. A letter from Merxhausen, dated 30th January 1715, stated that 'the hospital surgeon Johann Friedrich Müller had died approximately eight days ago and had left behind his wife (who had been ill for the past two years) alongside three small children in a miserable and wretched condition'. Two applicants had, on the day of writing, put themselves forward for the post. One was Johann Conradt Mertz, born in Kassel, and the other was Johann Peter Möller, the brother of the deceased surgeon.[128] The latter appears to have previously been employed as a surgeon for the military.[129] Mertz was more than qualified for the position. In his application to the Landgrave, dated 9th February 1715, he explained that he had served Prince Charle of Philippsthal as a valet (*Kammerdiener*) in Denmark and, in the former siege of Tönningen, he had worked with the elderly *Lazareth* surgeon in Sieburg. Through this employment Mertz had however been unable to enjoy even 'the lowest fee' and 'did not know how to make a profit' through his work in Kassel. He was therefore applying for the position in Merxhausen in the hope that this position would improve his situation. From the brief career history that he offers the reader we learn that he had served as a surgeon in many military campaigns, 'living with the troops'. He had been employed in this manner 'during the previous French wars' and had also served with the 'blue *Dragoner*, the cavalry (*Leibregiment zu Pferde*) and the Lüneburg troops. He had also worked as a naval surgeon (*zur See chirurgisch tätig war*) and, seven years after passing his exams he had become a *Chirurgus ordinarius* in Kassel.

In spite of Mertz's qualifications, Johann Peter Müller was accepted as Merxhausen's '*Hospitalsfeldscher*' (a term that was frequently used for 'army

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[127] See among others, Winston, Mark, 'The Bethel at Norwich: An Eighteenth-Century Hospital for Lunatics', Medical History, 1994, 38, pp. 27 – 51, here p. 48.
[128] StAM, Bestand 229I, BIIb, Paket 6.
[129] StAM, Bestand BIIb, Paket 6.

doctors' in this period).[130] He was to be paid a yearly salary of one 'quarter' (*Viertel*) of corn, one pair of shoes and three *Cammergulden*. The reasons for this appointment seem to be connected more to issues of familial and institutional obligation to relatives of the deceased than to medical prowess. As the superintendent from Geismar pointed out in his correspondence, according to an agreement of 1650, the 'high hospitals' were responsible for the care of an employee's family after their death (i.e. widows and small children). The former surgeon had left behind a wife who was consumptive (*schwindsüchtig*) and three small children. His brother, Johann Peter Müller had agreed at the time of his application that, should he be offered the job, he would take on the care of his relatives. It would appear that this was a principal factor behind his appointment. Müller seems however to have been successful in his job. He served the hospital for forty-seven years until his death, and was praised by the Landgraves for his work.[131]

Medical practitioners clearly played an important part in hospital life, and many individuals remained in the service of the institutions for a considerable period of time, presumably building up some form of patient – client relationship with the inmates, many of whom were similarly long-serving. It is clear from correspondence that these employees were themselves aware of their integral role and they lobbied for their pay to reflect their workload and service offered. The hospital authorities likewise seemed willing to accommodate these requests. In May 1721, for example, Johann Peter Müller wrote to the visitation commission, the superintendent and the council and deputies, asking for increased pay. He explained that, when originally appointed, he was commissioned to care for approximately eighty persons, visiting them once a week. The numbers had constantly increased and had now reached approximately two hundred individuals. Consequently it was no longer sufficient to visit once a week – his workload had effectively doubled. He was now unable to survive on his previous salary and requested more subsistence items to act as

[130] This situation seems to contrast to that for Haina. Wickel suggests that 'From 1703 to 1820 there was a surgeon [living] in the institution [Haina] itself'. (Wickel, 'Provincial', p. 446.) Quite why this differentiation occurred between the two hospitals is at present unclear.

[131] StAM, Bestand 5, Nr 18308. Much of this information can also be found in Grebe, 'Chirurgi', p. 284.

payment, such as corn, salt and oats. The decision was made to immediately offer Müller an additional quarter of both corn and oats, and an extra wood allowance.[132]

This was not the only complaint lodged by Müller. After sixteen years of service at Merxhausen, he requested another pay rise. He stated that for the past nine or ten years he had been forced – due to an increased hospital population – to visit the establishment twice a week. For each visit he received quarter of a pound of cheese and 1 *Maas* of beer in addition to his yearly salary.[133] He lamented that the distance that he had to travel from Gudensberg (one of the nearest towns) to Merxhausen necessitated the use of a horse, and reiterated that he had to do far more work than his predecessors for much the same pay. He bemoaned the low wage that he received (three *Cammergulden*, five quarters of corn, one quarter of oats, one pair of shoes and one bundle of wood), and requested that this should rise with an additional amount of oats and wood and an extra two *Cammergulden* being paid to him. Evidently he considered the raise given to him in 1721 to have been insufficient. The council quickly decided to increase his wages.[134]

Müller was not alone in his quest for higher wages. Similar concerns are evident in the correspondence of Franz Israel, the Haina hospital surgeon (*Bader*) from 1725. Employed to bathe the inmates, and also to shave them and cut their hair, Israel complained that whereas he had to previously visit the institution on twelve occasions during the year, this had now risen to twenty attendances. Israel attributed such demand to the fact that the numbers of the poor in Haina had increased by one third in recent years. The extra work had not been reflected in his wages – he still received only two measures (*Malter*) of corn and two pairs of shoes per annum, and he requested that this be reviewed.[135] It appears that these demands were met.[136]

In the context of early modern expectations, both Haina and Merxhausen can be viewed as 'hospitals'. While not suggesting that medical care was the primary

[132] StAM, Bestand BIIb, Paket 4.
[133] According to Schlieper, one *Maas* of beer was equivalent to 1.949 litres. Schlieper, 'Ernährung', p. 218.
[134] StAM, Bestand 229I, Rechnungen – Belege, 1730.
[135] For more information regarding *Malter* see Schlieper, 'Ernährung', p. 218.

issue within these institutions – religion, work, food and general aspects of care were also crucial aspects of daily life – it nevertheless played a much greater role than it has hitherto been afforded in studies to date.

Having offered an in-depth picture of many facets of hospital life that indicates the sort of experiences that a potential inmate could expect to have, we will now turn to the petitions themselves. How did the application criteria as listed in the foundation ordinance translate in the correspondence itself? How did factors such as old age and chronic conditions affected a person's decision to apply to enter these institutions?

[136] LWV, Bestand 13, Bittschriften (uncatalogued).

CHAPTER FOUR
THE EXPERIENCE OF OLD AGE AND THE TERRITORIAL HOSPITALS.

I. Historiography of old age in the early modern period.

The debate surrounding the position of the elderly in pre-industrial society is one which has been accorded a great deal of interest in recent years and has been studied from a variety of vantage points, including demography, medicine, literature, and social history. To date, however, the prime focus has rested upon the period immediately surrounding the onset of industrialisation. A central feature of this work has entailed a comparative assessment of the social position of the old within the pre-industrial household- and community. Debates over the existence of the 'golden age of ageing' have held an important position, as have studies questioning the existence of 'a simple causal relationship between the status of the aged and societal development', and the 'scarcity value' of the aged themselves.[1] Prime areas of concern have been the effect of industrialisation upon the social and economic position of the elderly and the place of the aged within their familial and social framework. Studies of household structure have been particularly prevalent. Upon the premise that its treatment of the elderly is an acid test of the society in question, much time has been expended in seeking out largely statistical evidence to assess this criteria.

One criticism of previous historical studies of old age has been that frequently it is 'old age that has attracted attention rather than the elderly themselves'.[2] This state of affairs is particularly true of European studies of the period from the sixteenth to the mid-eighteenth-centuries and especially within the few German works devoted to this topic.[3] Specific studies of the 'experience' of the old are

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[1] Thomas, Keith, 'Age and Authority in Early Modern England', Proceedings of the British Academy, 62, 1976, pp. 205 – 248.

[2] Pelling, Margaret & Smith, Richard E., 'Introduction', in Pelling, Margaret & Smith, Richard E. (eds), Life, Death and the Elderly, London & New York, 1994, (1st edition 1991), here p.1. Similar comments have been made by Troyansky, David, in Idem, Old Age in the Old Regime. Image and Experience in Eighteenth-Century France, Ithaca & London, 1989, p. 4.

[3] Work includes Jütte, Robert, 'Aging and Body Image in the Sixteenth-Century Hermann Weinsberg's (1518 - 1597) Perception of the Aging Body', European History Quarterly XVIII, 1987, pp. 259 - 290; Welte, Manfred, 'Das Alter im Mittelalter und in der Fruhen Neuzeit',

rare - at best the elderly are mentioned in passing, usually under the rubric of widowhood, or as one category of hospital inmate.[4] Source survival rates (and possibly also the agendas of historians) have meant that the sixteenth- and seventeenth-centuries are frequently underrepresented in histories of old age. [5] Where studies do exist, they have frequently based themselves upon the records of the poor. Surviving documentation regarding the poor in the sixteenth- and seventeenth-centuries often results in research involving either statistical accounts regarding distribution of poor relief as it related to the impoverished elderly as a group, or the position of the elderly with regards to ordinances. The tendency has been to regard old age as a social problem to the extent that the actual experience of this phase of life among the elderly poor is all too frequently missing. It is therefore important to bear in mind that these records seem to privilege the elderly, and to beware of making sweeping generalisations about this social group that the records themselves may not bear out. While not denying that old age and poverty often went hand in hand, it must be noted that when we speak about the 'elderly poor', we are thus referring to a group of the poor who are also elderly. We are not suggesting that these experiences are indicative of all aged persons.

Schweizerische Zeitschrift für Geschichte XXXVII, 1987, pp. 1 - 32; Borscheid, Peter, 'Der alte Mensch in der Vergangenheit', in Bates, Paul B. & Mittelstrass, Jürgen (hrsg), Zukunft des Alterns und gesellschaftliche Entwicklung, Berlin & New York, 1992, pp. 35 - 61; Borscheid, Peter, Geschichte des Alters. Vom Spätmittelalter zum 18. Jahrhundert, Münster, 1987. Regarding the latter work, see, among others, the comments of Troyansky, 'Balancing', pp. 96 – 109. The relative lack of work in Germany on this subject is further suggested in the bibliography regarding 'Alter' in Münch, Paul, Lebensformen in der Frühen Neuzeit, Berlin, Neuausgabe 1998, (Originalausgabe 1992), p. 510. See also von Engelhardt, Dietrich, 'Altern zwischen Natur und Kultur. Kulturgeschichte des Alters', in Borscheid, Peter (hrsg.), Alter und Gesellschaft, Stuttgart, 1995, pp. 13 - 24; Jütte, Robert, 'Daily Life in Late Medieval and Early Modern Germany', in Scribner, Bob (ed.), Germany. A New Social and Economic History. Volume 1: 1450 - 1630, London, 1996, p. 347.

[4] It can be argued that much of the information regarding the 'experience' of old age in the early modern period, have come from studies wherein such an analysis was not their primary objective. Regarding hospitals, see, among others, Kinzelbach, Gesundbleiben, pp. 100, 325, 327-8, 341. Compare to Boldt-Stülzebach, Annette, 'Das Leben im Hospital - Die Altersversorgung in der Stadt Braunschweig im Mittelalter und in der Frühen Neuzeit', in Geschichte des Alters in ihren Zeugnissen von der Antike bis zur Gegenwart, Braunschweigisches Landesmuseum, Braunschweig, 1993, pp. 47 - 54. Regarding widowhood, see among others, Taylor, Irmgard C., Das Bild der Witwe in der deutschen Literatur, Darmstadt, 1980; Roper, Holy, pp. 49 - 54; Wunder, 'Sonn', especially chapter 7; Freist, Dagmar, 'Religious difference and the experience of widowhood in seventeenth- and eighteenth-century Germany', in Cavallo, Sandra & Warner, Lyndan (eds.), Widowhood in medieval and early modern Europe, London & New York, 1999, pp. 164 - 178. It must be remembered that widowhood was not implicitly connected to old age.

[5] Regarding German sources, see, for example, the brief comments of Robert Jütte in his article, 'Poverty' , pp. 385 - 389.

In focusing upon pauper petitions from sixteenth- and seventeenth- rural Hesse in Germany, this study aims to address some of the issues relating to old age which have hitherto been largely ignored by scholars. In real and practical terms, what did it mean to be poor and old in the early modern period? How did old age affect a person's ability to labour, and what effect did this have, especially among a class that was dependent for its survival upon its ability to work? How did one arrive at the point of applying for entry into one of the institutions under consideration in this chapter? Concentrating upon petitions written by, and on behalf of, the elderly poor in Hesse, this chapter will endeavour to shed light upon the expectations and reality of old age among the rural populace, from both an individual and a communal vantage point. Experience of old age will be discussed through a consideration of potential changes in the social role and importance of the elderly individual, and the issue of labour during old age. This chapter will focus upon the aged as they appear in the documents as prospective patients. As will be seen in the next chapter, this group also plays an important role as carers, thus offering an alternative perspective of old age in this period. The setting for this study is both localised and specific, dealing in total with two particular groups of the elderly poor (in this chapter the petitioners, and in Chapter Five, the carers) in this particular region of Germany.

II. The aged in the territorial hospitals.

As discussed in Chapter One, the foundation of the *Landeshospitäler* comprised one part of Philip the Magnanimous' scheme to care for the poor and sick in the Hessian territories. One of the main aims of this project was 'the improved care of persons suffering from infirmity and the ailments associated with old age'.[6] The earliest *Landesspitäler* ordinances revealed that one of their prime objectives was to offer care for the elderly. Old age was defined as over sixty years of age and 'according to one Hessen hospital order: "... it would be then that one would be so broken down that he could not earn his bread."'[7] The emphasis on decrepitude is further enhanced in the *Landesspitäler* ordinance of 1534, written

[6] Schenk, Geschichte, p. 4.
[7] Cited in William, Capitalism, p. 191.

by the superintendent of the hospital. It was stated here that 'persons under the age of sixty were only allowed to be taken in when their impotence was such that they were fit for nothing else'.[8] For their applications to be considered, the incapacitation of the younger applicants had, in theory at least, to mirror that of their elder counterparts. Sixty years was regarded (at least by the Landgraves and the hospital officials) as the benchmark by which one could be classified as 'old'.

The Hessian authorities not only viewed old age as a distinct phase of life but, irrespective of gender, also perceived those persons aged over sixty years as being more likely, from a physical vantage point at least, to be incapable of supporting themselves. This provision further suggests that the 'over-sixties' were a large and needy enough group to receive this recognition, and that society as a whole was realised to be otherwise failing to care for this sector of the population.[9] As will be discussed in Chapter Five, such a stance would thus add further weight to Thomas' conjecture that 'the golden age' of ageing and communal and familial provision for the elderly are, in reality, largely mythical - in the case of the poor classes at least.[10] In the instance of the Hessian hospitals it would appear that for these applicants the 'locus of care' within the family and community had broken down to such an extent that they were now required to turn to the state.[11]

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[8] German transcription in Demandt, 'Hohen', p. 49

[9] Some urban institutions in France, the Low Countries, and Northern Italy, also appear to have 'consistently identified the elderly as a category of inmate that was disproportionately large in relation to its share of the local population'. See Pelling & Smith, 'Introduction', Life, fn. 78. Compare, among others, to Jütte, 'Poor Relief', pp. 383 – 385.

[10] Thomas, 'Age'.

[11] Horden, Peregrine & Smith, Richard S. (eds.), The Locus of Care: Family, Community, institutions and the provision of welfare since antiquity, London, 1998. See especially, Martin Dinges, 'Self-Help and Reciprocity in Parish Assistance: Bordeaux in the 16th & 17th Centuries', in Locus, pp. 111 - 124; Cavallo, 'Family'; Jütte, Poverty, pp. 83 – 99.

III. Old age as an illness? The debilitating effects of advancing years.

The 1535 foundation ordinance stated 'that ... no one under the age of 60 years should be accepted. Were this the case, it would be a person so infirm that he [or she] is otherwise unable to earn his [or her] bread and nourishment through work, [and] is capable of no form of service'.[12] Younger patients were therefore meant to have no other means of supporting themselves, either by their own actions or through the assistance of others. The hospital petitions indicate, however, that the majority of the applicants did not solely deem their age to be responsible for their request to enter Haina or Merxhausen. The individual was normally also chronically ill and without any other means of support. It must be borne in mind that the information evinced in these sources offers a specific and localised view of old age. The detail found within thus cannot be taken as indicative of the experiences of all of the Hessian elderly per se, but of those who were unable to fend for themselves any longer, and thus turned to hospital care and were accepted for entry. From this perspective, it is perhaps unsurprising that the close connection between old age and debilitating illness is immediately evident from the numerous *Landesspitäler* documents that concern the aged. At the same time, the richness of the sources provide us with detailed information regarding the elderly's experience of old age. Such cases 'provide a rare personal record of what the poorest people of society felt and thought, including such intimate matters as the suffering from illness and the experience of old age'.[13] They also offer the historian a viewpoint against which to compare opinion regarding an individual's experience of their advanced years that was found in contemporary popular and learned culture.[14]

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[12] LWV, Bestand 13, Hospitals-Ordnungen und Vergleiche, (Haina). Hospital Ordnung von 1535; StAM, Bestand 17I, Nr 2366. In the case of Merxhausen and Hofheim, the feminine forms replaced the masculine – i.e. she ... her...

[13] Sokoll, 'Old Age', in Chronicling, p. 127.

[14] Such a focus is unfortunately outside the scope of this chapter. Concerning this literature of old age, see, among others, Borscheid, Geschichte, especially chapter 1; Burrows, James A, The Ages of Man, New York & Oxford, 1986; Cole, Thomas R. & Winkler, Mary G., The Oxford Book of Aging, Oxford & New York, 1994; Demaitre, Luke, 'The Care and Extension of Old Age in Medieval Medicine', in Sheehan, Michael M. (ed.), Aging and the Aged in Medieval Europe, Toronto, 1990, pp. 3 - 22; Freeman, Joseph T., Aging's history and literature, New York, 1979; Hanawalt, Barbara A. The Ties that Bound. Peasant Families in Medieval England, Oxford, 1986, pp. 238 – 240; Lüth, Paul, Geschichte der Geriatrie. Dreitausend Jahre Physiologie, Pathologie, und Therapie des alten Menschen, Stuttgart, 1965, esp. pp. 126 – 159; Palmer, Richard, 'Health, Hygiene & Longevity in Medieval Renaissance Europe', in Kawakita,

It is immediately clear that many applicants linked their present infirmities to their seniority. In her petition of 1619, for example, Curdt Schrieber's widow referred to being 'besieged by old age'.[15] Similarly, in 1616, the widow Kuna Scheffer from Loelbach (Löhlbach) explained that she was suffering from 'the difficult burden and frailty of old age'. As a result she was afflicted with problems of comprehension, being rendered as an imbecile. Furthermore, her hands shook, and all of her limbs felt tired and heavy. She was consequently no longer able to earn her keep, and was also unable to 'collect alms from the doors of other people'. A similar predicament confronted Gertraudt Ewel, from the village of 'Buphain'.[16] Her application of 1616, when she was almost 80-years old, revealed that her husband had died approximately nine years previously, and since that time she had lost her physical strength through old age and all manner of illnesses and infirmities. As is so common in these petitions, she was consequently unable either to earn her own keep or to collect alms from other people.[17]

Such infirmities were not the sole preserve of female applicants. Similar physical problems cross the gender divide. This is evidenced, for instance, in the 1716 documentation relating to Jacob Schöneweißes, a 'poor, old, and now almost blind man, [who was a] native of Alten Lohtheim [sic] in the domain (*Herrschafft*) of Itter'. In his correspondence with the visitation commission,

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Yosio, Sakai, Shizu & Otsuka, Yasuo (eds.), History of Hygiene. Proceedings of the 12th International Symposium on the Comparative History of Medicine – East and West. August 30 – September 6, 1987, Japan, Tokyo & Missouri, U.S.A., 1991, pp. 75 – 98; Shahar, S., Growing Old in the Middle Ages. "Winter clothes us in shadow and pain, translated from the Hebrew by Yael Lotan, London & New York, 1997 (1st edition 1995), pp. 36 - 59; Troyansky, Old, especially chapters 3 & 5; Dove, Mary, The Perfect Age of a Man's Life, Cambridge, 1986, especially chapter 3. Medical works which focus on old age include: Bacon, Roger, The Cure of Old Age, and the Preservation of Youth, Shewing How to Cure, and keep uff the Accids of Old Age; and how to preserve the Youth, Strength and Beauty of the Mind. By that Great Mathematician and Physician Roger Bacon. A Franciscan Friar. Translated out of the Latin with Annotations and an Account of his Life and Writings. By Richard Browne, London, 1683. Wellcome Institute for the History of Medicine, London MSL Collection. Early Printed Books; Smith, John, King Solomons Portraiture of Old Age. Whereis contained A Sacred Anatomy both of Soul and Body, and a Perfect Account of the Infirmities of Age, incident to them both. And all those Mystical and Enigmatical Symptomes, expressed in the six former Verses of the 12th Chapter of Ecclesiastes, are here Paraphrased and made plain and easie to a mean Capacity, London, 1666, Wellcome Institute for the History of Medicine, London MSL Collection. Early Printed Books; Schipperges, Heinrich, Die Kranken im Mittelalter, München, 1993, pp. 53 – 57.

[15] LWV, Bestand 17, Reskripte, 1616

[16] Both of these cases can be found in LWV, Bestand 17, Reskripte, 1619.

[17] Ibid, Reskripte, 1616.

Jacob recounted: '[I have spent] almost all of my life, from my youth onwards, as a cowherd'. Through this occupation he had been able to support himself. He was unable to do this any longer as a result of 'both old age and disability and failing sight'. Regarding the latter he lamented that it had become 'so dim and diminished'. Unless he was guided, he was unable to find his way. As a result he had been forced 'to give up [his job as a] cowherd'. His 'poor wife' was 'now ... also old and of advanced years [and] without accommodation, shelter or food', and he was reduced to searching for his sustenance 'at the doors of [other] people'. His failing eyesight meant that he was even unable to continue this begging, for he could not mobilise himself without someone else to assist him. Jacob was at a loss as to how to improve this situation. Entrance into Haina was his last hope.[18]

In the minds of the elderly petitioners, old age was interconnected with declining health. This phase of life was most frequently associated with physical conditions that involved some form of weakening - most commonly, a lack of physical strength, involving loss of mobility and stamina. Fundamentally, these petitions depicted old age as a time of (seemingly rapid) decline and loss of physical attributes, be they concerned with the faculties of sight, hearing, (or, occasionally, reason), or with the fundamental capabilities of mobility.

IV. What is Old? Medical versus Lay Interpretations as evinced in the petitions.

In the early modern period, geriatrics, like paediatrics, was still not viewed as a separate medical discipline.[19] Mention of old age, in so far as it is found in medical works, occurs most frequently as an incidental section, or relates to the long-running quest for longevity and eternal youth.[20] Similarly, old age is

[18] LWV, Bestand 13, Reskripte, 1716.

[19] See, among others, von Kondratowitz, Hans-Joachim, 'The Medicalisation of Old Age: Continuity and Change in Germany from the late Eighteenth- to the Early Twentieth-Century', in Pelling & Smith (eds.), Life, pp. 134–164; Thane, Pat, 'Geriatrics', in Bynum, W. F. & Porter, R. (eds.), Companion Encyclopedia of the History of Medicine: Volume 2, London, 1997 (1st edition 1993), pp. 1092–1115.

[20] See among others, Palmer, 'Health'.

frequently commented upon in literary sources that focus upon 'the ages of man'.[21] In all of these topics, little consensus was achieved between the various schools of thought. This is especially true concerning the potential number of 'life-stages' of man, whereby numbers ranged widely from three upwards. I am yet to find specifically learned medical references in any of the petitions that relate to a particular author or school of thought concerning old age It is clear that the elderly applicants reviewed their lives within stages. As will be shown here, at their simplest, these 'stages' (as they appeared in these documents) corresponded to the interwoven factors of physical and mental capabilities and the ability to undertake some form of work, be it paid employment or begging.

Notions regarding the progressions of old age as evinced in the *Reskripte*, compare most closely to the medical thoughts of Paré, among others. Paré distinguished between old age (which he deemed to begin just after one reached the age of 35), when one was still capable of happiness and dealing with business, and "mature old age" (from 50 years), when one's capacities faded, and one required assistance with food and clothing. The final, decrepit stage saw the body dying away, a relapse back to childhood, and the inevitability of death.[22] When we consider that, even today, consensus is rarely reached regarding the various phases of old age, we should perhaps not apply Paré's distinctions too rigidly. Nevertheless, it is worth assessing whether similarities existed between the understanding of old age as evinced in both the Hessian petitions and the learned manuscripts. (Specific references to the 'childhood' phase are uncommon in the correspondence of the elderly and physical ill persons.) Perhaps the main difference between this learned time-scale and the *Reskripte* concerns the temporal division of the 'stages'. The impression gleaned from the petitions is that the transition from the second to the third stages could occur much later in life, and is also much swifter. In spite of these differences, the essence of Paré's life-cycle demarcations seems to correspond closely to the various stages that are encountered in the petitions under consideration here. In

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[21] Generally, the term 'man' was used to denote both the male and female life-course. See especially, Dove, Perfect, especially chapter 3. For a discussion of the stages of a woman's life, see Wunder, Sun, pp. 16-36.

[22] Cited in Rosenthal, Joel T., Old Age in Medieval England, USA, 1996, p. 98. See also pp. 99, 180 - 182, regarding learned opinion concerning the ages/stages of man.

the first phase, one is old but still able to undertake some form of work. During the following stage, one is forced to live upon alms until, finally, one becomes totally dependent, and seeks hospitalisation.

Some differentiation was made by the petitioners regarding the various stages of old age that one could experience. According to Rosenthal, 'one of the keys to a recognised distinction between maturity and old age (or "post-maturity") is the idea of the institution of retirement'.[23] We will illustrate that this statement appears, in general, to be borne out by the Hessian sources. For the labouring poor who are documented here this was just one of the stages. Moreover, the 'retirement' phase is not something that these individuals strove for, relying as they did upon their ability to provide for themselves through work. Enforced retirement and the subsequent call for hospitalisation occurred for some of the petitioners when they were around eighty years of age. The petitions leave one with the impression that, in the mind of both the applicants and of those who are providing either corroboratory testimonies or are appealing on the invalid's behalf, the whole process of the 'final stages of ageing' occurred in a relatively short period of time – a few years at most. This conviction may well stem from the effects of memory, but, considering the range of people who had to corroborate this occurrence (such as neighbours, local officials and former employees), this is unlikely. It is clear that many of the petitioners retained their paid employment well into their old age – well past the sixty-year mark that the founder had initially deemed to be a time that many would require assistance due to disabilities.

Most of the elderly petitioners knew their ages. In some cases, age was referred to in approximate terms, but in many instances precise terms were used. It can be suggested, as Margaret Pelling does in her study of elderly widows in Norwich, that the incidence of round figures as ages (e. g. seventy, eighty, etc) might be evidence of estimation. Nevertheless, the fact that the testimonies had to be corroborated by other people meant that the ages given had to be considered

[23]Ibid, p. 100.

plausible.[24] An understanding of age differentiation on the part of the elderly is also evident in those petitions in which an old person applied for a younger person, usually a relative, to be admitted into the hospital. In the case of children especially, their age was stipulated. The evidence from the petitions suggests (in a way which mirrors the findings of the work of Sara Mendelson and Patricia Crawford on early modern England) that while some of the cases include ages that may have been rounded out, others are more specific.[25] The 1586 list of Haina patients includes both types of examples. While Henne Mocks from Mohnhausen was registered as being eighty years of age, and Kunz from Münchhausen in the district of Battenberg was noted as being aged seventy, more specific references were given. For instance, Hans Krebs from Rosenthal was sixty-four years old, Jungjenne Röder from Wollmar in the district of Battenberg appeared in the accounts as a sixty-eight year-old man, and Theiß Born from Asphe in the district of Wetter was seventy-three.[26]

'Old age' was, in a sense, given its own force. Growing old was depicted as a process. Subjectively an individual would see and feel his or her body ageing and would consider him- or herself to be old. Presumably society agreed with this categorisation.[27] In common with the literature of the period, one gains the impression from the petitions that certain ailments and illness where viewed as accompanying old age, and were thus explained from this vantage point. Blindness, frailty and immobility were frequently seen as being irrevocably linked to this time of life. It is almost as if old age itself was being portrayed as the overriding illness. It may be tentatively suggested that, as modern anthropological studies have shown, there existed an 'altered presentation of illness in many old people', whereby certain symptoms, more common to the elderly are connected to their age, and are to a large extent even expected.[28] This

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[24] Pelling, Margaret, 'Old Age, Poverty and Disability in Early Modern Norwich: Work, Remarriage and Other Expedients', in Idem, Common, pp. 135 - 138. Compare to Posner, Richard A. Aging and Old Age, Chicago, 1995, pp. 204 – 205. Regarding estimation of age, see also Thomas, Keith, 'Numeracy in Early Modern England', Transactions of the Royal Historical Society, 5th series, 37, 1987, pp. 113, 126. Compare to Mendelson, Sara & Crawford, Patricia, Women in Early Modern England, 1550 – 1720, Oxford, 1998, pp. 185 – 186.

[25] Mendelson & Crawford, Women, pp. 185 – 186.

[26] The list is transcribed in Demandt, 'Hohen', pp. 116 – 117.

[27] See also Mendelson & Crawford, Women, p. 184.

[28] Brocklehurst, John 'Aging and Health', in Hobman, David (ed.), The Social Challenge of Ageing, London, 1978, pp. 149 - 171, here p. 159

might be partially explained by the fact that it was not until the nineteenth century that it was considered that any of the ailments associated with old age might be curable.[29] Nevertheless, it could be argued that such a sentiment continues today - if not from the vantage point of the medical profession than at least from the subjective viewpoint of the elderly themselves. As the anthropologist Dorothy Jerrome has shown in her modern study of old age, the elderly seem to expect to suffer from a certain amount of physical difficulties as part and parcel of their seniority.[30] Research into ageing in the twentieth-century has shown that 'old people will put up with their pain, incontinence, falling, depression and a host of other symptoms because they have such a low expectation of health'.[31] Through the consultation of a wide number of case studies, we will endeavour in this chapter to ascertain how these modern-day expectations compared to the early modern experience of old age.

The language of the petitions suggests that a graduated experience of old age was a common theme in the popular mind, and that the differentiation between the various stages of life was incorporated into the linguistic usage of the populace. (Whether and how this 'knowledge' was connected to learned works current in this period is a question that constraints of space will not permit to be included in this chapter.) It may be that such divisions were based upon observation and experience. If this was so, then it is possible to argue that, in comparison to the viewpoint of the state, the lay person did not attribute any specific year as signifying the start of old age. The latter's perception placed greater emphasis upon external and functional features, such as one's ability to work.[32] While the

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[29] Concerning the 'curability' of old age, see, among others, von Kondratowitz, 'Medicalisation', pp. 134 – 164; Porter, Roy, 'Senile Dementia', in Berrios, German & Porter, Roy (eds.), A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders, London, 1995, pp. 52 – 62; Fennell, G., Phillipson, Chris & Evers, Helen, Sociology of Old Age, Milton Keynes & Philadelphia, 1988, pp. 39 – 41; Thane, 'Geriatrics' , pp. 1092 – 1115. Compare to Jones, Colin & Brockliss, Laurence, The Medical World of Early Modern France, Oxford, 1997, p. 62; Kinzelbach, Gesundbleiben, p. 298

[30] Jerrome, Dorothy, Good Company. An Anthropological Study of Old People in Groups, Edinburgh, 1992, pp. 93 - 94. See also Brocklehurst, 'Aging', p. 163. For nineteenth-century examples of descriptions of old age amongst a farming population, see, among others, Hopf Droste, Marie-Luise, Das baüerliche Tagebuch: Fest und Alltag auf einem Artländer Bauernhof, 1873 – 1919, Museumsdorf Cloppenburg (u. a.), Materialien zur Volkskultur nordwestliches Niedersachsen, 3, 1981.

[31] Brocklehurst, 'Aging', p. 163.

[32] Compare to van Dülmen, Kultur, Erster Band, p. 200; also Sieder, R, 'Probleme des Alterns im Strukturwandel der Familie', in Mitterauer-Sieder, Vom Patriarchat zum Partnerschaft, p. 169ff.

precise age divisions of such 'life-cycle stages' related largely to the individual, it appears that the petitioners distinguished between someone being 'old' (*alt*), and of 'advanced old age' (*hohen alter*). The latter term seemingly denoted those who had been both forced to give up any forms of employment, and were unable to collect alms. It was usually during this latter phase that hospitalisation was sought. The word 'decrepit' (*abgelebt*) was used upon occasion in conjunction with the latter phase.

One crucial aspect of old age that runs through the petitions concerns immobility. In the aforementioned case of Jacob Schönweißes – as indeed in so many others – this was brought about by blindness. As will be shown in due course, the elderly seem to have been able to cope sufficiently with many illnesses and weaknesses. It is only when mobility became 'too arduous' for them, or, when they were rendered wholly immobile, and were thus unable even to go out and seek alms for themselves, that they were no longer able to be self-sufficient. Applications frequently arose at this juncture in their life-cycle.[33] One could argue therefore that many of these applicants are referring to the burden of advanced old age. They also distinguished between the stages within the broad category of 'old'.

The notion of old age being synonymous with childish qualities (usually negative ones) as stipulated in the medical literature of the period, does not appear to have been as prevalent in the petitions as one might have expected. Admittedly this thesis largely restricts itself to considering individuals suffering from predominantly physical rather than mental conditions. Nevertheless, considering the advanced age of many of these petitioners, we would expect (according to the contemporary medical definition) that they would also be experiencing some mental problems. Comparisons between the elderly and children rarely occurred in the sources considered here. As Shahar's study of old age in the late medieval

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In contrast to van Dülmen's assertion that old age was also signified by an individual's appearance, the documents consulted here rarely make reference to such external features. Regarding the importance of appearance and the 'elderly face', see Botelho, Lynn, 'Old Age and Menopause in rural women of early modern Suffolk', in Botelho, Lynn & Thane, Pat (eds.), Women and Ageing in British Society since 1500, London, 2000, pp. 43 – 65, here pp. 53 – 56.

period has revealed, learned opinion tended to equate this phase of life with the negative qualities of childhood – usually those connected to inability of comprehension or function. Paré, in his account of the final stage of life, referred to the body dying away and a relapse back to childhood. While there may be some cases which refer solely to the person as aged and suffering from some form of mental illness connected with 'childishness', it would appear that, from the sixteenth- to the early eighteenth-centuries at least, many of the cases referring to old age focus more frequently on the accompanying physical deficiencies.

Age-based distinctions are also evident in the 1612 funeral sermon for Jan von Döbernitz, the Chief cupbearer of Brandenberg. The tract reads:

> *At ten a child,*
> *At twenty a young man,*
> *At thirty a man,*
> *At forty well established,*
> *At fifty at his peak,*
> *At sixty the onset of old age,*
> *At seventy an old man,*
> *At eighty forgetful,*
> *At ninety the laughing stock of children.*
> *At a hundred God have mercy.*[34]

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[33] Compare, for instance, to Rosenthal, Old, p. 101 - 103. Also, Shahar, Growing, especially pp. 98 - 170; Orme, Nicholas, 'Sufferings of the Clergy. Illness and Old Age in Exeter diocese, 1300 - 1540', in Pelling & Smith (eds.), Life, pp. 62 - 73.

[34] Cited in Imhof, Verlorenen, p. 144. Translated in Wunder, Sun, p. 16. Compare these distinctions to Jacques' speech in William Shakespeare's *As You Like* It, II, vii:

> '*... one man in his time plays many parts,*
> *His act being seven ages*
> *... And the sixth stage shifts*
> *Into the lean and slipper'd pantaloon,*
> *With spectacles on nose and pouch on side;*
> *His youthful hose, well sav'd a world too wide*
> *For his shrunk shank, and his big manly voice,*
> *Turning again towards childish treble, pipes*
> *And whistles in his sound. Last scene of all,*
> *That ends this strange eventful history,*
> *Is second childishness and mere oblivion,*
> *Sans teeth, sans eyes, sans taste, sans everything.*'

Considering that Döbernitz died at the age of seventy-two, this literary description is clearly not meant to depict his life. Indeed, one could read this as an indication that he died at the right time – before the horror of old age set in.

By comparison, literary descriptions of women's old age clearly emphasise the differences between the genders in the experience of old age. This, according to Heide Wunder, stands in stark contrast to visual imagery in which the male and female's ageing process is depicted as being analogous. It also is counter to the policy of the Hessian state which set sixty as a benchmark age irrespective of gender.[35] Johann Fischart's publication of 1578, for instance, described the 'ages' of woman thus:

> *At ten a child,*
> *At twenty a maid,*
> *At thirty a wife,*
> *At forty a matron,*
> *At fifty a grandmother,*
> *At sixty age-worn,*
> *At seventy deformed,*
> *At eighty barren and cold.*[36]

This is just one of many literary descriptions of the aged woman and it is not within the confines of this thesis to offer an in-depth discussion regarding this source base. It is interesting to note however that in these texts the woman is noted as ageing earlier than the man. The latter was afforded the greater likelihood of living past eighty years. The reference to the sixty year old would also suggest that this change was also visually more obvious – although if this were the case it would then contradict the analogy suggested by visual representation. Interestingly enough, however, mental weakness was deemed to be the sole attribute of the elderly male. More comparative research is needed into this topic to ascertain how representative these texts are.

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[35] Wunder, Sun, p. 16.

[36] Fischart, Johann, Das Philisophisch Ehzuchtbüchlein, Strassburg, 1578, in Scheible, Johann (ed.), Johann Fischart's Flöhhatz, Weibertratz, Ehzuchtbüchlein, Podagrammisch Trostbüchlein sammt zehen kleineren Schriften, Stuttgart, 1848. Reprint of 1578 edition. Cited and translated in Wunder, Sun,

In comparison to the impression that one would glean from consulting learned documents, the physical and mental aspects of old age were not always interlinked in the petitions. References to mental illness were, on the whole, largely absent from the sources focused upon in this study. (Obviously further comparative study of the mental illness cases is necessary to ascertain whether a distinct form of malady was attributed to the elderly.) Instead of witnessing the anticipated (from a learned viewpoint at least) progression into insanity and childishness, in the cases where mental and physical affliction are mentioned in one individual, one is left with the distinct impression that the condition was viewed more as an incidence of mental confusion. While an intensive study of cases involving mental illnesses will shed further light on this question, it would appear from the sources that I have so far consulted, that cases of mental illness usually related to younger petitioners – with the majority of the violently mad falling in the younger age bracket.[37] When the elderly suffered these maladies they were generally described as part of the ageing process, or were related to an ongoing illness from which the patient had been suffering – most notably epilepsy.[38] The latter instance frequently occurred in younger applicants also. The illness and the resulting mental disorder thus took precedence over the age of the afflicted. Mental illness was regarded as an element within the process of ageing that was linked to incapacity. It would appear therefore that certain forms of insanity – largely those illnesses related to confusion – were affected in, and expected of, the old.[39] This observation gains further credibility when one considers that, in the 1534 ordinance, it was specifically stated that prayers should not last longer than half an hour so that 'the memory of the elderly will not be overstretched'. [40]

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p. 16.

[37] For examples from 1586, see the patient list transcribed in Demandt, 'Hohen', pp. 122 – 123.

[38] For example, 'In 1714 Conradt Neuroth in Lischeid (near Treysa) requested that his mother-in-law, the widowed Elisabeth Wiesemann, "who has been suffering from the falling sickness for four years and because of it has lapsed into a complete frenzy, so that he can no longer keep her without danger or maintain her on account of his poverty", be admitted into the state hospital of Merxhausen...'. Cited in Wunder, Sun, p. 35.

[39] It would thus appear that these findings are closer to the stance of Thomas, than to that of Demaitre. See the latter, 'Care', pp. 10 – 11.

[40] Cited in Demandt, 'Hohen', p. 49.

The connection between declining health and old age is a central component of the petitions written by, or on behalf of, the elderly in sixteenth- and seventeenth-century rural Hesse. An 'inescapable process', the physical afflictions associated with this phase of life had long been a feature of the associated medical, didactic and moralistic texts. [41] In the late Middle Ages, for instance, in *'The Pilgrimage of Human Life'*, Guillaume de Deguileville described the situation thus:

Disease leans on crutches, and Old Age has legs of lead.

Comparatively, in the 1515 Shrovetide play (*Fastnachspiel)* in Gegenbach, Germany, the elderly person was portrayed as being discontented, deaf and blind. He explained that his 'legs creak' and he required two crutches to facilitate his mobility. To him, old age was an 'evil guest'.[42] In the Hessian petitions, however, one has the sense that it was only within the later phases of old age – the phase that provoked the application for admission – that such discontentment set in. Many of the petitions also illustrate the continuing social role of the elderly. Prior to their applications, these individuals had often been able to labour and support themselves for a not inconsiderable period of time. In many respects, the experience of old age was much more multi-faceted than popular or learned culture would suggest.

V. Ageing as an incidental factor?

An assessment of old age is a complex and highly subjective matter and we should not assume that all aged applicants viewed the onset of old age as the primary cause of their plight. In some instances the petitioner seems to have regarded their age as an incidental factor and they attributed their desperate situation to other physical causes. Examples exist throughout the period of study. In the 1577 correspondence relating to Adam Bingel from Storckelhaußen, he deemed himself to be 'a poor, old, lame man without means' who had always supported himself and his children through hard work [*harte, saure und schwere arbeit*]. When however his 'age and inability [*unvermögen*]' meant that he was

[41] See also Rosenthal, Old, pp. 106 – 107.
[42] Borscheid, Geschichte, p. 13.

no longer able to undertake such activities, he turned instead to herding cattle, and had been employed in this way by his neighbour for quite a number of years. His age did not, therefore, prevent him from working, but merely ensured that he altered his career to fit in with his physical capabilities. Bingel presently found himself unable to undertake even this employment as a cow-herd. The reason for this was not, however, specifically connected to his age, but rather to misfortune. As a result of 'a darned fall [*mistlichen fall*]' he was now 'completely lame in one arm', and could no longer work.[43]

In comparison, although Johannes Bretzen (from Obern Urff in Borken) was seventy years of age when he applied to Haina in 1709, the accompanying report from Abraham Kuhn, the treasurer (*Rentmeister*) of Borken did not dwell on this fact. Recounting a conversation that he had had with the applicant, Kuhn stressed Bretzen's other (unrelated) physical incapacities. (Interestingly enough, the following conditions were summarised in the hospital official's comments as *'gebrechlich'*, reiterating once more the catch-all nature of this term.) Some years previously, Bretzen had been involved in 'some accidents'. A dung-cart had run over his right leg and, 'at Siberderoda [sic], where he had at the time been herding sheep' he had broken his left leg in two. He had lost his hearing, and had no-one to care for him – his three sons had been killed in military service. While not the primary cause of his misfortune, it would appear that Bretzen's advancing years had placed an added strain upon an already tenuous situation. He could not envisage how he would be able to support himself in the future, and thus offered to pay his final 10 *Reichsthaler* to the hospital in return for being accepted as an inmate.[44] An accident had thus prevented him from continuing in the one line of employment that his age left open to him.

Similarities are also evident in the 1739 application of Jacob Rohleder (from Lobenhaußen in the district of Milsungen). Once again, the official's summary reduced Rohleder's plight to that of 'old age, poverty and impotence (*gebrechlichkeit*)'. Rohleder signed himself as a 'poor, suffering (*elender*), impotent subject'. Landgrave Wilhelm by contrast, added that Rohleder ' [is] a

[43] LWV, Bestand 13, Reskripte, 1577.
[44] Ibid, 1709.

really poor man who is burdened with two severe ruptures (*starcken bruchen*)'. Jacob's report offers much more detail regarding the actual nature of these infirmities. It is clear that while his advanced age was not seen as the prime cause of his physical misfortune, it had exacerbated an existing situation to such an extent as to render him unable to cope. Describing himself as a 'poor, old, impotent, seventy-two year old man', Jacob explained that 'for the past fifty years [he had been] really burdened on both sides with a secret [or internal?] hurt [*mit heimlicher schaden*]'. As a result of these 'injuries', Jacob had been 'unable to hold back ... [his] urine'. Added to this, he stated: 'in my advanced old age [*hohen alter*] [I] have no food and as a result of the great and arduous weakness ... [I am] also unable to earn even the smallest amount of money [*keinen heller verdienen kann*], [I] also have no-one who would be able to provide me with food'. His helplessness meant that he was unable to go to other people to seek alms and assistance from them. It also prevented him from appealing to such kind-hearted persons at all. Jacob had two sons but they were both in military service at the time and were thus unable to assist their father. He stated that he 'does not know how ... [he], in... [his] advanced old age and [with his] burdensome severe physical infirmities', would be able to support himself for the rest of his life.[45] The report of J. C. Waldschmidt, the pastor from Grebenauden, revealed that he had checked the church records (*Kirchenbuch*) and could confirm the applicant's age – suggesting that in this locality at least, and at this point in time, it was possible to know one's age. He described Rohleder as 'severely broken [*hart gebrochen*]'. In spite of his physical frailties, Rohleder had lived a godly way of life (*gottseeligen wandel*). He was however 'also poor, so that his age and inability [*unvermögen*] have left him without nourishment...'. If we take the pastor's report as being indicative of the community's view of this individual, it is clear that society categorised Jacob as old and helpless, even if his medical condition revealed that other issues were also responsible for his condition.

We are fortunate that the doctor's report for this case survives and is also relatively detailed. It offers an interesting counterpart to the comments of the

[45] LWV, Bestand 13, Reskripte, 1739.

pastor above. It must be noted that the physician, Georg Wagener from Kassel, made no mention of the applicant's age. Instead, having seen Jacob's condition, Wagener described it thus: 'on [his] left side [he] had a considerable *herniam inguinalem completam*, on the right side however one of the same kind, yet *incompletam* detectable, to which malady the supplicant's perpetual incontinance [*Urine incontinentia*]' was connected.[46]

As well as offering us a view both of the experience of old age and also of living with a chronic condition, this source reveals the dangers of translating early modern material and the inaccuracies that can arise if one is only given limited information. In German, '*bruch*' can mean either 'a fracture' or 'a rupture'. How are we to interpret these occasional 'shady' areas, where multiple meanings can be found in one term? Had only the pastor's report survived alongside the Landgrave's summary letter, as was often the case with the earlier petitions, we might have gained a different perspective. After all, the pastor merely stressed Rohleder's frailties. It must be constantly borne in mind therefore that although these documents offer us a much more detailed picture of the lay person's chronic illnesses that can be gleaned from the more commonly used documentation of patient lists, they are still not without their drawbacks. This seems particularly to be the case with the expression '*gebrechlich*', a term which can include (and thereby mask) a wide range of debilitating conditions.

Documentation from 1727 relating to Johannes Becker from Niedern Vorschütz in the district of Felßberg is even more indicative of this potential problem. Becker described himself as 'a poor, old [sic] seventy-six year old, very frail man'. He was suffering from what would appear at first glance to be 'a severe fracture [*starcken bruch*]'. He had previously supported himself as a cowherd but, since the age of fifty-three, he was no longer able to continue this line of work. This was due to both his advanced old age (*hohen alter*) and his impotence (*gebrechlichkeit*). He had no other way of 'earning his bread'. In addition, he was homeless and also wholly without means. This situation caused him great worry and he was often forced to go hungry.

[46] Ibid, 1739.

So far we would have no reason to doubt that Becker was suffering from anything other than frailty and perhaps a fracture. Two points in the accompanying letter from the district officials of Felßberg however suggests that the reality of the situation might be other than it at first appeared. The correspondence was written in a list form. It referred specifically to the 1722 ordinance and gave what it considers to be four corresponding answers (to unstipulated questions). Items three and four are of interest to us:

3) 'the supplicant gives his age as seventy-six years and [he] is severely broken [*starck gebrochen*] ... on both sides, which [injuries] by their appearance look very serious [*gefährlich*, and thus by implication, are a risk to his health].'

4) 'He reports continuously that in his youth he had been attended to by a doctor but that the medicine had not wanted to take effect.'[47]

From the similarities to the earlier case – most notably the use of the term '*starck gebrochen*', and the fact that specific mention was made to the condition being on 'both sides', it seems reasonable to assume that Becker, like Rohleder, was also suffering from a double hernia.

It would appear that issues of age were more likely to be of secondary importance when an individual was suffering from a pressing illness such as a double hernia. The 1717 case of Peter Kruppel from Dodenhausen offers further indication that, in cases of incapacitating illness, the disease itself was usually of greater importance than the age of the invalid. Kruppel, a 'poor, old, decrepit, eighty-year old and totally ailing [*siechelhaft*] man', recounted that he was suffering from a lengthy illness which had 'made him very swollen'. As a result of this, he had been house-bound since Michaelmas and was 'unable to go outdoors'. (Indeed, the pastor described him as 'bedridden'.) Owning nothing other than his small house (*Haußgen*), Kruppel relied on his ability to work to provide for himself, his wife and his children. Unable to earn 'even a crumb of bread', the family was therefore in a miserable state and 'must suffer great hunger'.[48] Presumably Kruppel believed that if he entered Haina, the burden that he represented would be lifted from his family, who would then stand a slightly better chance of being able to be self-sufficient.

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[47] Ibid, 1727.
[48] Ibid, 1717.

Old age obviously played a role in the petitions above, but it was not always the primary one. One senses that in the cases in which other physical conditions were cited as the main motivation behind the application, this emphasis had as much to do with the subjectivity of the individual supplicant as with the infirmity itself. None of these documents denied that old age necessitated changes in lifestyle. Indeed, we learn from Adam Bingel that his advanced years had forced a change in career many years previously. The decisive factor that caused him to apply to the hospital was not his age but rather the result of a fall. The common theme within each of these case studies is the way in which an external event – either an accident or an illness – had caused the acceleration of their descent into incapacity. While their seniority had long been lurking in the background, they had expected to be able to continue to support themselves in the foreseeable future. Other events changed this outlook however, and it was these issues that defined most clearly their new, incapacitated identity rather than their position as elderly persons. This factor may explain why, as noted in Chapter Two, the descriptions of patients' conditions in the hospital account books frequently listed physical infirmities rather than the simple categorisation of 'aged' that the foundation ordinance would lead one to believe would have been sufficient justification for admission.

A study of old age requires a much subtler understanding than it has hitherto been afforded. One of the overriding – and hitherto all too often ignored – themes which arises from the case studies considered here relates to the social role of the aged. This usually displays itself within the remit of employment. All of the persons considered above displayed a remarkable ability to continue working throughout their lives. It is to questions of the ability of the elderly to earn their keep that the second part of this chapter will now turn.

VI. Work and the Elderly.

In his seminal essay regarding ageing in seventeenth-century England, Keith Thomas asserted that 'for those whose earning capacity depended on their physical strength, old age had little to commend it'.[49] Given the conditions under which it was necessary for potential applicants to be suffering, the association between physical incapacity (connected as it has been shown, to old age) and enforced retirement, as evinced in the petitions, is perhaps unsurprising. It is of note, however, that the petitioners frequently described their social situation in terms of their past and present employment opportunities. For the labouring poor, with no possessions of their own to fall back on, being unable to work could irrevocably weaken one's social position. In many instances, the applicants attempted to use the position afforded them in their previous employment to ingratiate themselves in some way with the relevant authorities. Such petitioners tried to establish some notion of prior service to the local authorities and the state, in the hope that some form of reciprocal bond would thereby be created.

A quintessential theme of the petitions of the elderly rests upon the assertion that they were willing to work, but their physical - and, upon occasion, their mental - incapacity, which was a direct result of their age, had rendered this impossible. In effect therefore, old age was portrayed as a force of nature, against which mankind is powerless. Numerous petitions regarding cases unconnected with old age, (but concerning a variety of physical illnesses) emphasise that the burden of their affliction had been sent to them by God. This stance is rarely in the documentation relating to the elderly, in which they described their experience of old age. The 'retirement' phase that features in the Hessian petitions is enforced through physical (or occasionally mental) incapacity. It is apparent that many of the petitioners retained their paid employment well into their old age - and it would appear, well past the sixty-year mark that the founder had initially deemed to be a time that many would require assistance due to debilities.[50]

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[49] Thomas, 'Age', pp. 205 – 248. Cited in Pelling & Smith, 'Introduction', p. 4.

[50] This can be compared, for example, to the discoveries that have been made by Imhof and Schumacher in their study concerning causes of death in Giessen and its surrounding areas in the eighteenth- and nineteenth-centuries. Imhof, Arthur E. & Schumacher, Helmut, 'Todesursachen', in Imhof, A. E. (hrsg.) Historische Demographie als Sozialgeschichte. Giessen und Umgebung

As has been alluded to in Chapter Three – and as will be considered in Chapter Six – some of those persons employed by the hospital also retained their positions until an advanced age. While this may seem at odds with the sixty-year boundary line imposed by the founder, these instances indicate that Philipp the Magnanimous was not suggesting that all individuals over the age of sixty would be incapable of working, but that this was more commonly the case. After all, the ordinances stated that all who were able to perform any sort of work within the institutions should do so. Age was not a stipulated factor. In this sense, capability overrode the age barrier. This may explain the existence of elderly persons employed in the service of the hospitals. For instance, Caspar Fuhrhans took up the position of governor (*Vogt*) in Merxhausen in 1722, having moved from his position as *Fruchtschreiber* in Haina.[51] In his previous job, Fuhrhans would have been responsible for accounting for the usage of fruit, poultry, flour and bread. It would appear that the transition between these two offices was not uncommon.[52] This no doubt stemmed from the fact that the prospective governor would have already proved his accounting skills in his previous position. In his correspondence of 1739, Fuhrhans gave his age as seventy years. If this is correct this means that he was fifty-three at the time that he originally took up the position at Merxhausen. In 1739, Fuhrhans requested that this youngest son be allowed to assist him in his duties, as he was no longer able to manage everything on his own. The *Obervorsteher* William of Urff expressed his support for this idea, stating that he knew Fuhrhans' condition to be such 'that one ... does not know how long this old hospital official (*Hospitalbeamte*), whose disability increases day by day, will [be able] to last'. We can assume, however, that perhaps the most crucial factor motivating this decision rested, not in a sense

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vom 17. zum 19. Jahrhundert, Teil 1, Hessische Historische Kommission für Hessen,, Darmstadt & Marburg, 1975, pp. 559 - 625. See especially pp. 615 - 616, Figs. 16 & 17.

[51] According to the terms of the 1573 ordinance that duties of the Fruchtschreiber were as follows: '*Er soll mit der Frucht getreulich umgehen, sie neben dem Federvieh rechtzeitig einbringen und sie nicht von einem Jahr zum andern verschleppen; dazu selbst darauf sehen daß die in der Hospitalscheune ausgedroschene Frucht aufs beste gelagert und nichts davon ohne Befehl veraüßert wird. Er hat Müller und Bäcker zu beaufsichtigen, daß sie mit Mehl und Brot treulich umgehen, und wenn gebacken wird, jedesmal selbst dabei zu sein und die Einnahme der Brote aufzuzeichnen, damit man aus seiner Wochenrechnung ersehen kann, wohin sie augegeben worden sind. Den Bäckergesellen soll er ihre Gebühr selbst verabfolgen und überall gute Ordnung halten gemäß seinem Eid und seiner Pflicht und wenn er Unrechtmäßiges bemerkt, es abstellen helfen*'. Quoted in Demandt, 'Hohen', p. 83.

of respect and nostalgia for the aged Fuhrhans, but instead in the figure of his son. The latter, Johann Friedrich Fuhrhans, had already helped his father in his duties for many years, seemingly to the great satisfaction of all. Urff expressed that he knew of no-one more suited for the task. It would seem reasonable to assume, therefore, that this correspondence was motivated not only by the father's declining health and advancing years, but also to ensure that the son would follow in the elder's career. Were this the case, the plan worked. Johann succeeded his father and remained in Merxhausen as the governor until his death in 1757.[53]

Evidence of many years of employment abound throughout the petitions. (Given that the intended primary consumers, the labouring poor, relied upon their ability to work for their survival, this should come as no surprise.) In 1703, for instance, Christoffel Schäfer, a 'poor and sick' man from Löhlbach requested hospital care. His letter to the visitation committee, the deputies and the *Obervorsteher* stated that he was a 'poor, eighty-two year old man [who was] now in a miserable condition'. God had sent him a 'heavy burden'- revealing the continued belief into the eighteenth century of the power of God to inflict illness. Twenty-six weeks previously, his leg had been 'affected' (in an unspecified manner), which had now rendered him unable to walk and thus incapable of earning his upkeep. He was born in Großen Ritte and had resided and worked there for forty years – no specific details are offered. As a result of 'these very distressing times', he had been forced to leave this place and went to *Closter* Merxhausen. (Note the continued eighteenth-century usage of the term *Closter* with relation to Merxhausen.) He had served in the hospital for twelve years as a cowherd and had also been an attendant (*Aufwarter*) in the 'large [sick-] room'. It would appear however that a bailiff (*Meÿer*) had been appointed to Merxhausen and that this man had to perform these duties as part of his job. As a result, Schäfer had left the hospital and had been employed as a cowherd 'in various places until, fifteen years previously ... [he] was taken on as a swineherd in Lohlbach.' He had diligently continued with these duties and had behaved

[52] Examples of this can be found in Zillinger, 'Vögte', pp. 271 – 272. It is interesting to note that, increasingly from the mid-eighteenth century onwards, the governors had formally worked in the legal profession. (Ibid, p. 272.)

himself in a befitting manner – 'as the whole community [*Gemeinde*] can attest' - until he was struck by a 'weakness' (*Schwachheit*) that left him incapable of working. As such, he asked to be taken into Haina as a 'poor decrepit brother'. His petition was accepted.[54]

It is not only men who charted their career paths within the petitions. In 1713, Susannen, the widow of Hanß Hermann Leÿsen from Martinhagen requested entrance into Merxhausen hospital 'due to her age and frail condition'. The local officials' correspondence (which referred to the institution as a *Closter*) revealed that 'according to her report [Susannen was] sixty-five years old'. As a result of a fall many years previously she had damaged her back to such an extent that 'the bone stuck out a long way'. Ten years previously she had given up her house to her daughter and son-in-law and had stayed with them up until now. She had managed, many years ago, to provide herself with a 'meagre diet' by acting as some form of messenger (*botten lauffen*). She had often been sent on journeys between ten and thirty miles away. In spite of the fact that she was 'really small and not unlike a dwarf', she was still considered capable of undertaking such a profession, although the underlying implication may have been that her size and physical condition made the job increasingly difficult.

Susannen – and seemingly her daughter and son-in-law – had many debts, and the petitioner was without even the smallest amount of money (*heller*). In her advanced old age (*hohen alters*) she was unable to undertake her delivery work any more and was therefore unable to feed herself any longer.[55] It would appear that, although she resided with her daughter and son-in-law, she was responsible for providing herself with her own food and provisions.

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[53] StAM, Bestand 5, Nr. 18305. Cited in Zillinger, 'Vögte', p. 272.
[54] LWV, Bestand 17, Reskripte, 1703.
[55] LWV, Bestand 17, Reskripte, 1713.

VII. Begging as a form of employment.

In her work on England, Margaret Pelling has suggested that the elderly were expected to fend for themselves, undertaking even the most menial jobs. Similarly studies of pauper censuses in England, most notably those by Margaret Pelling of Norwich, and also by Andrew Wear of the parish of St Bartholomew's Exchange in London, reveal a system whereby the elderly were expected to perform various tasks, including laundering and nursing, in return for poor relief.[56] In early modern Norwich, for instance, an eighty year old woman, 'a lame woman of one hand', still managed to spin with her good hand.[57] (In this period, old age and the inability to work were not necessarily interconnected.) Perhaps to an even greater extent, Angela Groppi's work on Rome from the sixteenth- to the nineteenth century reveals the expectation on the part of the authorities that old age alone should not rule out a capacity to work.[58] In the case of rural Hesse, however, it would appear that begging constituted an additional stage in the process of self-sufficiency and work. Even after the individual was unable, through reasons of failing health and increasing age, to find employment, they are still able to live on public charity in the form of alms. The petitions frequently refer to begging as if it was a form of work. The elderly only applied for full support in the form of hospitalisation when even this survival tactic was rendered useless, because of their increasing immobility. This is evident, for instance, in the 1630 case of Hans Liese [Leÿße] from 'Cuentell' in the district of Lichtenaw [sic].[59] His testimony recounted that he was a carpenter by trade, and that for many years he had worked on construction projects for not only the Landgrave's father, but also for his grandfather. He had served them both as a pious subject, acting loyally and obediently. At the time of his application, Liese

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[56] Pelling, 'Old', pp. 134 – 154; Wear, Andrew, 'Caring for the Sick Poor in St Bartholomew's Exchange: 1580 – 1676', Medical History, Supplement No. 11, 1991, pp. 41 – 60. Compare to, among others, Connors, Richard, 'Poor women, the parish and the politics of poverty', in Hannah Barker, & Elaine Chalus (eds.), Gender in Eighteenth-Century England: roles, representations and responsibilities, pp. 126 – 147, here pp. 140 – 142; Wiesner, Merry, Gender, Church and State in Early Modern Germany, London & New York, 1998, esp pp. 146, 149, 157; Idem, Working Women in Renaissance Germany, esp. pp. 92 - 93

[57] Quoted in Wiesner, Gender, p. 147.

[58] Groppi, Angela, 'Old people and flow of resources between generations in papal Rome (16th – 19th centuries)'. Paper presented at the 'Old Age in Pre-Industrial Society' conference, held at Ithaca College, U.S.A., in September 1999.

[59] LWV, Bestand 13, Reskripte, 1630.

was an eighty-year old man, who had lost both his hearing and his sight. Due to the physical infirmity he was unable to earn a living (literally 'to earn his bread') and was forced to rely upon the charity of pious Christians. His aforementioned physical infirmities prohibited most movement however. Although some form of charity might have been available to him, he was physically unable to reach it, and could, therefore, not benefit from it. Liese thus threw himself at the mercy of the Landgrave, and requested that, as a result of his advanced age and his impotence, he be granted admission to the hospital for the little time that was left of his life.

Evidently, the Landgrave called upon both the local officials and the local pastor to corroborate Hans Liese's report. On 25th January, 1630, Johannes Geissell, the local pastor, wrote to confirm that the supplicant was 'an old, decrepit, 80-year old man, without means', who had behaved well within his community and who 'must now look for his bread among pious Christians'. Liese was however no longer able to stand, nor to hear properly and his reason and his sense had also been wrestled from him. The local officials similarly corroborated the supplicant's account, adding that he had been in the service of the Landgrave's forefathers, and had spent all of his life working as a carpenter. As a result of his age and physical failings, he had been forced to give up his occupation, and had to live in the most extreme poverty.

In stressing his occupation and the services that he undertook for the former Landgraves, Hans Liese was portraying himself as both a loyal member of the state and, through his work ethic, as an upstanding member of the community at large. It could, perhaps, even be argued that in connecting himself with the present Landgrave's forefathers, the applicant was in some way transmuting their esteem and veneration to himself.

The search for alms appears in the petitions as a crucial part of work and self-support strategies. In the applications, the aged person was not only depicted as being physically incapable of working, but they had also reached the point where they were unable even to go out and collect alms. It is clear in such cases that from the time of the applicant's 'retirement', they had been sustaining themselves

from the charity of others, until the point whereby even this course of action was rendered impossible. In these cases, the experience of old age seemed to progress through these three basic stages:

(1) enforced retirement thorough physical incapacity

(2) an inability to continue to collect alms or to support oneself (most commonly due to some form of mobility deficiency)

(3) an application to a territorial hospital.

Having survived on communal charity for as long as possible, the invalid turned to the state in the form of the territorial hospital to provide its own form of familial and communal care. The invalid hoped to find the practical and personal care within this institution that was missing from their lives. The collection of alms had sufficed as long as the seeker could make the effort to physically go out and search for them. When this life-cycle strategy had failed, the petitioner sought for charity and support within the confines of the hospital.

In spite of the fact that these petitions concern a Protestant territory, the practice of begging still continued, in the rural areas, and amongst the petitioners at least. Moreover, the frankness and frequency with which this topic was addressed in the pauper petitions suggests that the practice of seeking alms was an accepted, or at least tolerated, aspect of life in the communities of the applicants, if not also further afield. Such an apparent discrepancy might be explained by recourse to notions regarding the 'deserving poor', and communal care networks. One gains a sense that the negative aspects of their begging activities were, to some extent, allayed by their age, their long history of employment and their struggle to maintain their survival and their networks of self-help. These were the 'worthy poor' whose medical conditions prevented them from working, rather than the work-shy, malingering vagrants so commonly condemned in legislation.

The issue of 'worthy' or 'deserving' paupers is neatly encapsulated in the 1712 report from Johann Christoph Arnnd (the *Berginspector* of Neutershaußen). The document related to a seventy-year old petitioner, Christoph Hainemann from Blanckenbach. Hainemann was described as being besieged with many infirmities (*gebrechen*). Arnnd explained that he had been instructed to offer details of the petitioner's life history and to judge whether he was 'worthy'

(*wurdig*) of a place in Haina. The supplicant's life story that Arnnd recounted offers a good indication of the downward progression of an individual into a state of absolute misery. Hainemann was born in Waldt Cappell but had later moved to Blanckenbach. His wife had died four years previously, and he had sold their 'small house' for fifty-two *Reichsthaler*. He had already spent twenty *Reichsthaler* of this sum and wished to give the remaining monies – stated here as thirty *Reichsthaler*! – to Haina. Having spoken to the pastor and 'community' (*Gemeinde*) of Blackenbach, Arnnd could confirm that this individual had maintained himself in a Christian, honourable and neighbourly manner. The report from the locale stated that Christoph had lived in their community for fourteen years. He had supported himself through linen weaving and also through the transportation and selling of some (unspecified) goods. He had thus managed to feed himself in an honest and honourable way, and had also behaved in a friendly and neighbourly manner. He would thus appear to be an archetypal member of the 'worthy poor'. Having reached seventy years of age, his back and limbs had apparently been affected – presumably weakened. The greatest effect was upon his 'right leg, which he [had] crushed in his youth'. It had now 'become stiff and frail'. Arnnd explained that, as a result of his age, Hainemann was unable to undertake strenuous work (*saurer arbieth* - sic) and could not therefore feed himself any longer. The official continued: '[Hainemann] is ashamed that [apart] from the 30 *Reichsthaler* [all of his monies have been] completely consumed [and he must] search for his bread at the doors [of other people] and this is his true state of affairs'. Interestingly enough, Arnnd admitted that he did 'not know however whether this man is worthy of being accepted into the Haina Hospital'. Neither did he know for how long the thirty *Reichsthaler* would suffice to cover Hainemann's maintenance within the institution. According to Arnnd, the reason for such confusion was his own ignorance in the matter. He was unable to offer any more detail because, as he explained, 'neither the foundation of this high hospital after the hospital order (*Hospitals Abscheidt*) ... of 1650 nor the provision order (*Verpflegungs ordnung*) are known to me ...'. If we take this statement as true, it poses questions regarding the presumed fame of the territorial hospitals. Perhaps most interestingly, it also suggests that both

Arrnd and Hainemann's local authorities viewed the notion of the 'worthy' sick poor in the same way as the Landgrave and state.[60]

Evidence from a range of petitions reveals that the practice of alms-seeking was an accepted activity throughout the period and was even encouraged by the state as a form of communal poor relief. This was in spite of the many ordinances promulgated against vagrants and (presumably unworthy) beggars.[61] In the 1727 case regarding the aforementioned Johannes Becker, for instance, the accompanying letter from the district officials of Felßberg contains evidence of this policy. It referred specifically to the 1722 ordinance and gave what it considered to be four corresponding answers (to unstipulated questions). It is the first answer that concerns us here: 'As a result of [his] age and [his] inabilities [*unvermöglichkeit*] he [Johannes Becker] is unable to seek his piece of bread at the doors of good-hearted people'.[62] This usage of begging is contrary to Martin Dinges' assertion that self-help mechanisms in this period did not include begging.[63] In rural Hesse, by comparison, begging seems to have been one of the main sources of self-help. Perhaps the most important motivation may concern ideas of reciprocity. It appears that, unlike vagrants, the petitioners sought alms close to their home. Whether this is due to the fact that their advancing years have rendered all attempts at begging further afield useless is unknown. It may be simply that, for the most part, these cases seem to involve people who felt that they had served their community in some way in their younger days, and they were now searching for reciprocal assistance from the same community when age and illness had forced them to retire. As is evident in many parts of early modern Europe, it appears that the authorities were content to let the community be the first point of call for aid to an individual, and that it was only when all such resources had been utilised that the state would step in and offer

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[60] LWV, Bestand 13, Reskripte, 1712.

[61] See among others, Schott, Claudia, Armenfürsorge, Bettelwesen und Vagantenbekämpfung in der Reichsabtei Salem, Bühl / Baden, 1978, pp. 5 – 23; Jütte, Robert, Abbild und Soziale Wirklichkeit des Bettler- und Gaunertums zu Beginn der Neuzeit. Sozial-, mentalitats- und sprachgeschichtliche Studien zum *Liber Vagatorum* (1510), Köln, 1988, especially pp. 48 – 51; Jütte, Obrigkeitliche, pp. 203 – 208.

[62] LWV, Bestand 13, Reskripte, 1727.

[63] Dinges, 'Self-Help', p. 113. Regarding begging in rural areas, see also the comments of Robert Jütte in, 'Poverty', pp. 393 - 393, 398 (also fn 21 concerning the common chest in general). Compare to Kinzelbach, Gesundbleiben, esp. p. 124.

institutionalised care.[64] It would seem therefore that these two types of 'worthiness' are interconnected. Those 'worthy' to collect alms within the locality also appear to have been 'worthy' of a place in the hospital, provided that they met the other criteria.[65] (It must be remembered however that this viewpoint might merely be a product of the sources. Not all of those who sought alms would necessarily apply for entry to the territorial hospitals. Similarly, as the cases in which the application was rejected have not as yet been unearthed - or, more likely, have not survived - we do not know whether instances exist in which 'worthy' alms seekers were denied a place in the *Landesspitäler*).

From the 1704 case of Aile Hessin from Alten Haina (in the district of Haina), it would appear that begging was also accepted among former employees of the hospital. Describing herself as 'an ... old (*alte und betagte*), lame and very infirm (*gebrechlich*) maid (*Magd*)', she adds that 'because of my lameness that [I] got as a result of a bad fall [*schweren fall*] [whilst] in the service of the hospital and [which] increases with my approaching seventieth year, ... [I] am unable to earn my bread either through work or through begging'. In addition she no longer knew of any friends with whom she would be able to stay – it would appear that she had already exhausted thus source of care. Aile finally noted that she 'also has a melancholy breathing [presumably referring to some respiratory difficulties] which make her quite weak and feeble [*matt und krafftloß*] ...'.[66] Whether she deemed this condition as being directly related to her age was not stated. It is clear however, that one of the reasons that she considered herself eligible for entry to Merxhausen related not only to her previous employment therein, but also to the injuries from which she suffered as a result of her time there. It is interesting to note that no mention is made of the hospital taking responsibility for this condition in the form of any aid (financial or otherwise). Aila seems to have connected the lameness that she suffered as the result of an external force (i.e. an accident) to the internal force of the ageing process. The latter evidently increased the severity of the former.

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[64] See also Wright, Capitalism, p. 189; Midelfort, 'Madness', p. 350. Compare to Cavallo, 'Family'.
[65] Reference to the latter concept can be found in (among other petitions) LWV, Bestand 13, Reskripte, 1717 (Peter Kruppel).
[66] LWV, Bestand 17, Reskripte, 1704.

VIII. Retirement and service.

In a manner akin to that which the medieval studies of Rosenthal and Shahar have shown to be employed in the petitions for retirement from various state and church employees, some of the aged supplicants used their employment to the state in an effort to secure themselves a position in the territorial hospitals. Such individuals endeavoured to create a semblance of a reciprocal bond through emphasising a prior notion of service. This ploy is especially true of cases where the applicant (or, in the case of female applicants in particular, a member of their immediate family) had previously served as either a pastor, in military service, or in some capacity in one of the hospitals in question. Such a device can be viewed as a further attempt by the claimant to add emphasis to their case, from a position whereby their only form of power or bargaining tool stemmed from the wretchedness of their existence. It is, of course, possible that preferential treatment was extended to former employees and their immediate families. As illustrated in Chapter Three, from at least 1650, the 'high hospitals' were responsible for the care of an employee's family after their death. Whether this programme extended to some form of provision of care for elderly employees is unknown. Were this the case, it could be argued that the state (as the hospital patron) was offering its employees a form of retirement facility. Whether this was particularly true when the petitioners or their relatives worked in the hospital is a matter that requires further research – as will be shown, retired soldiers also entered the hospital with increasing frequency throughout the period. It is not unthinkable, however, that having lived within the hospital community for many years, a former employee would have had an advantage over other petitioners. Among other things, they would probably have had more of a chance to develop the social bonds that might prove fruitful to them in the future - particularly amongst the hospital administration.

An extensive period of service - and, in some cases the undertaking of a range of employment within this appointment - is a common feature of the petitions. Aside from offering information regarding issues concerned with medical and welfare issues, these documents also frequently convey much detail about the life history of the potential patient. As is evident throughout all of the petitions, one

senses that the elderly were managing their old age and the various ailments that they suffered by changing their occupations and lifestyles as far as possible to fit their physical capabilities. This is also true of those supplicants who had previously undertaken some form of state service Chapter Six will deal more extensively with notions of work, service, and obligatory aid. For the purposes of this section of the thesis, we will consider briefly the petitions of the aged who worked within the territorial hospitals. How did they describe their experience of old age?

In 1672, for instance, Andreas Senff, a former employee of Haina, petitioned the Regent Landgravin Hedwig Sophie for entry into the hospital. Senff, 'born in Marck Brandenburg', recounted his lengthy service at Haina. Firstly, he had worked for twelve years as a wool weaver. Subsequently he had served as a clothworker, serving the poor. For the past thirteen years of service, he had worked in the kitchens at Haina, and had also been involved in many other general tasks of service. In his advanced old age, however, and after much hard work, he was suffering from 'poverty, hunger and misery'. He appealed to the Landgrave to prevent him from being expelled from the hospital now that he was unable to perform his work. Instead, in respect of his many years of hard work and his advancing years, he wished to be admitted to Haina, and to spend the short time that was left of his life there. The Regent Landgravin agreed to this request (in principle at least).[67] This document can be seen as charting, in brief, the life course of this individual. While we have no details regarding the reasoning for the changes in career, it may be that the move from employment as a clothworker to a kitchen hand was connected to his advancing age. At any rate, it is certain that this is regarded as the ultimate cause for his inability to work.

Other employees of the *Landesspitäler* applied to be taken into the hospitals once they were no longer able to perform their duties. This included married couples who had both worked in the institutions, as, for instance, in the 1709 case of Ernst Meÿ and his wife. Meÿ was eighty years of age and had been in charge of the cellars (*Kellermeister*) in Merxhausen. Carl ordered that their request should

[67] LWV, Bestand 13. Reskripte, 1672.

be met, provided that it was considered that they 'merited' such provision. Ernst had worked in the hospital for at least nine years as a beer brewer and 'cellarman' (*Kellerman*). His wife had served the infirm (*presthafftige*) persons in Merxhausen as an attendant. Ernst's age had now meant that he was unable to continue with his duties any longer – an indication that he was already 'old' when he had commenced his employment in the hospital – and he was wholly unable to undertake any strenuous work. The salaries that this couple had commanded from their employment were so low, that they had no resources to fall back on. Hence the petition.[68] Similarly, in 1710, Caspar Breidenbach, the ninety-year old former bailiff (*Meÿer*) in Haina, requested that he and his wife be taken into the hospital and be cared for there.[69]

While further research needs to be undertaken into the issue of retirement, service and illness – including comparative analysis – it would appear that the petitioners who were working in some capacity in the hospitals frequently considered it sufficient merely to describe themselves as 'old'. Presumably they would have been known to those who would be processing their applications, most especially the *Obervorsteher*, and they would thus not deem it necessary to detail their physical experience of ageing. Their advancing years would have gradually been evident to the rest of the hospital population, and also to other persons involved in the institutions' administration, such as the visitation committee and perhaps also the Landgraves. Alternatively they may have felt that their position afforded them the right to such care, and that further detail was unnecessary. This suggestion might be borne out if we consider cases from the areas surrounding the hospitals. For instance, the petitions from individuals in Löhlbach, the village neighbouring Haina, offered similar descriptions to those from further away – although personal references to hospital officials were more often included. When one considers that Löhlbach was under Haina's jurisdiction, and that the *Vogt* of Haina was also that of Löhlbach, one might have assumed that similar patterns would occur in the correspondence stemming from both of these areas. More research is required however for these suggestions to be borne out. It would be interesting to know, for example, if

[68] LWV, Bestand 17, Reskripte, 1709.
[69] LWV, Bestand 13, Reskripte, 1710.

these divergences continued or became more pronounced after the 1728 ordinance which clearly stipulated as one of its conditions that all applications should be accompanied by a medical report and a clear indication of the medical conditions of the subject. Did this affect the petitions of the elderly hospital employees, or did they simply remain 'old'?

Not all of the elderly former servants would automatically apply for a place in the hospitals. Some requested instead a form of 'pension' (*Altersrente*) for their services. In June 1762, Johann Peter Möller, the barber-surgeon for Merxhausen, wrote to both of the Landgraves with such a request. Möller had worked for the institution for forty-two years, and had always been commended by the state for his diligent service. In his 1762 request he wrote, as 'an old man (*Greis*) of seventy-eight years, who had willingly sacrificed the greatest part of his life in the service of his most wretched of all people'. Wishing to retire, he requested that the Landgrave provide him with a 'meagre salary' so that he could purchase wood and fruit. The Landgraves acceded this wish and provided him with a 'gracious stipend [*Gnaden=Gehalt*] for the rest of his life'. It is unknown for how long he enjoyed this privilege.[70] From the limited information that we have at present, it would appear that Möller was able to support himself (either off his own bat or through the help of others), provided that he received this pension from the hospital. He thus did not need to apply to be admitted as a patient. The issue of individuals applying for extra-institutional care is an important matter that will be briefly considered in Chapter Five.

IX. The Subjective Experience of Old Age.

It is not enough to simply explain the process by which illness was encompassed under the rubric of old age in terms of the low life expectancy once the elderly gained entrance into the hospitals - that is, that their nearness to death overrode the question of their incurable state. Many of the petitions requested entry into the hospital for 'the short period of time' that the invalid may have left of his/her

[7] StAM, Bestand 5, Nr. 18308. Also cited in Grebe, 'Chirurgi', pp. 284 – 285.

life. This format is however common to many of these documents, and was not restricted to the petitions from the elderly. In the years for which comprehensive lists of patients in Haina survive (from 1717), it is evident that many of these elderly patients went on to reside in the hospital for many years. Johannes Stroh from Geismar in the district of Gutensberg [Gudensberg], for example, entered the hospital in 1712, at the age of 68, and remained there until his death, in 1719. Ditmaar Eÿerdantz from 'Buchenberg' in 'Itter', entered the hospital as an 'old and impotent man' in 1709, and stayed there until his death in 1726. Barthel Schäcke from Vöhl similarly spent the last years of his life (in this case from 1717 until 1723) in Haina.[71]

Nor can the references to the limited life expectations of the petitioners simply be dismissed as a rhetorical device to arouse sympathy and assistance. It is common for historians to assume that those applying for entry into institutions were all too eager to go to such places. Nevertheless, one gains a sense from these sources that, in some cases at least, (and especially where they concerned the elderly, and where the invalid was responsible for facilitating their own petition), the opposite may in fact have been true. Entry into the hospitals seems to have been very much the last resort. In the majority of cases, it would appear that only when an individual was wholly unable to support themselves - as aforementioned, usually because they were physically incapable of moving very far – was an application made. It could thus be argued that the stigma that was attached to entering such hospitals facilitated the greater likelihood of need on the part of those applying for entry. It must be borne in mind, however, that such a level of need was, to a large degree, a prerequisite criterion for application, as evinced in the foundation ordinances.

Such an unwillingness to enter these institutions might not simply have been due to the institutions themselves but might also have related to the subjective experience of the petitioner. As opposed to dismissing the elderly as a marginal

[71] LWV, Bestand 13, Kuchenjahresrechnungen. Such findings can be compared to the modern notion, as asserted by Marian Robinowitz, that 'in hospitals [today] a young patient might be described as a long-term patient, while an old one is said to be taking up a bed'. Cited in Shahar, Growing, p. 6. Compare also to Nutton, Vivian, 'Medieval Western Europe, 1000 - 1500', in Conrad et al, Western,

group who can only be studied in general terms, one gains a sense from these documents that the elderly accepted their increasing infirmities as a part of the ageing process, but did not deem this in itself to be sufficient cause for them to be incapable of caring for themselves. As modern anthropological studies have shown, it would appear that a personal expectation of some form of physical hardship in their advancing years means that the elderly's subjective view of their health may differ from the perceptions of others. According to Jerrome, for example, 'feeling well and enjoying good health does not depend on the absence of physical illness in old people'.[72]

X. Conclusion.

An in-depth study of the pauper petitions from the Hessian territorial hospitals allows one to gain a glimpse into the 'experience' of old age in the rural society of early modern Germany. Obviously, by the nature of their objectives, these sources focus upon a specific and localised sector of the elderly - namely the sick elderly poor who applied for admission into the Hessian *Landesspitäler* of Haina and Merxhausen. This is a social group whose voices often go unheard in the surviving documentation of the sixteenth- and seventeenth- centuries, and, as such, their investigation can still provide valuable insights, provided that sweeping generalisations are not presumed from such a focused study.

Surviving on an 'economy of makeshifts', evidence from the petitions suggest that the elderly rural poor viewed illness in a highly subjective way.[73] Many of the applicants had been suffering from a variety of physical ailments for quite some time, prior to their petitioning for a place in a hospital. Illness and the necessity of assistance and care were, in many ways, defined within terms of mobility and activity. Frequently, it was only when one was wholly unable to fulfil any social role, and was rendered immobile, that they applied to the hospital.

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p. 152.
[72] 'Jerrome, Good Company, p. 94.

Within a format reminiscent of the 'stages of life', the petitioners defined and described their advancing years and their worsening condition. As has been revealed, it would appear that the final descent into advanced age and incapacity was swift. At its simplest, the onset of old age meant that one was forced to retire or to undertake a simpler job. Advanced old age finally meant that one was unable to do anything other than beg, and, finally, decrepitude rendered even this impossible. A close study of the petitions thus reveals extra facets to the life-cycle of the elderly that have previously been neglected by historians - namely the use of begging as a tool of self-help, and the issue of immobility, whereby, in spite of old age, many people would deem themselves capable of providing for themselves, until they were literally unable to go out in search of sustenance. The onset of immobility thus signified an important threshhold into the final stage of the life cycle.

The importance of alms-giving and begging as a strategy for survival by the elderly, and the authorities' apparent tolerance for these activities by the aged, links in with notion of reciprocal care in this period. The petitions reveal that the applicants were frequently extremely conscious of their social role within the community, often stressing previous forms of employment. In a sense, they felt worthy of charity through their age and their previous services to the community. The possible loss of communal identity and subsequent stigmatisation which one may have faced by going into an institution may explain a perceived resistance to entering the hospitals. Alternatively, this reticence may be explained by looking at the notions of subjective views of health as mentioned here.

For the elderly in these sources, the hospital was their last resort - in many senses, not just for the individual, but also for the community who, frequently, could not afford to continue to subsidise chronic invalidity. The locality however, not only seems to have been willing to give alms but, it also played a central role in the network of care. Thus, in the case of early modern Hesse at least, there seems to be a progression from communal charity to institutional charity. These are seen as separate and subsequent phenomena, and not as

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[73] Quote from Hufton, Olwen, The Poor of Eighteenth-Century France, Oxford, 1974, pp.69 - 106.

alternative sources of assistance. This might be explained by the fact that once one entered a *Landesspital*, one could stay there for the rest of one's life, or it might conversely be a sign of staggered power and authority. In the first instance one was responsible for oneself and one's family. When this failed, one would turn to the authority of the community, and then subsequently to state support in the form of institutions.

By placing the elderly at the centre of a study concerning old age, one is able to gain a deeper understanding about the reality of old age in this period. By studying the experiences of the elderly, one gains insights not only into the life course of an individual, but also into the broader changes within society. Far from the marginalised and ridiculed figures in literature, the aged Hessian petitioners reveal that, despite their poverty and their infirmity, many still regarded themselves as having a designated, and at times important, role in society. To a large extent, they believed themselves to be capable of making their own decisions as to how their life course was to progress. Admittedly their social situation may have rendered many such decisions to have, in reality, been little more than choices against which there was little alternative. Nevertheless the experiences of the elderly as evinced in these documents reveal a continuing attempt on the part of the aged to adapt their lifestyle so that they could cope with their infirmities. Although their ultimate inability to be self-sufficient is evidenced in the very act of petitioning, their efforts to adapt offer us an alternative perspective of old age in the sixteenth- and seventeenth-centuries than is perhaps gleaned from statistical studies of poor relief and household structure.

Having considered the individual's experience of chronic incapacity from the viewpoint of the elderly, the next chapter will broaden the perspective to consider the perception of the carer(s). For the aged at least, it would appear that, just as in terms of labour the elderly poor in the petitions progressed from a position of employment and self-sufficiency – albeit frequently within a framework of poverty – a similar descent is evident in issues concerning care. The applicant would first look to themselves, and then to their family. If this failed, they would turn to the community, before, finally turning to the state in the form of the hospitals. What did this really mean in terms of the 'experience

of sickness' and the survival strategies employed by the ailing individual? Questions such as these will form the focus of the following chapter.

CHAPTER 5
PRE-PETITION CARE? THE ROLE OF THE FAMILY AND COMMUNITY IN MEDICAL AND WELFARE PROVISION

I. Historiography of Familial Care Networks.

In 1988, Robert Jütte called for historians to pay more attention to the role of the family in connection with illness in the early modern period. Categorising hospitalisation as the 'absolute exception', Jütte lamented that in spite of the fact that the early modern state of 'being ill' was inextricably entwined within the household unit (and thus within a familial framework), historians had hitherto ignored this connection.[1] To a large extent, and particularly with regard to the poorer classes, this neglect remains today.

To date, the history of the family has overwhelmingly centred around concerns of historical demography and debates over specific terminologies and categorisation. Quantitative frameworks regarding the size and composition of the early modern family - be they 'nuclear', 'stem', 'extended', or 'complex' - have abounded.[2] Such studies have doubtless been important in drawing our attention to the social composition of the family network but, as has frequently been noted at length, the theoretical framework behind them is not without its drawbacks and limitations. As Sandro Lombardini's studies of family, kin, and community in early modern Italy have suggested, by treating 'family, or for that matter, communities, as normative concepts', historians are implementing categories which are 'often inadequate to effectively portray the actual workings

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[1] Jütte, Robert, "Wo kein Weib ist, da seufzet der Kranke'- Familie und Krankheit im 16. Jahrhundert', Jahrbuch des Instituts für Geschichte der Medizin der Robert Bosch Stiftung, 1988, Band 7, pp. 7 – 24, here p. 7. Regarding the importance of family history to hospital history, see also Horden, Peregrine, 'A Discipline of Relevance: The Historiography of the Later Medieval Hospital', Social History of Medicine, 1, 1988, pp. 359 – 374.

[2] Lack of space prevents a fuller elucidation of such arguments - for more information, see, among others, the work by the Cambridge Group for the History of Population and Social Structures. For example, Laslett, Peter, The World We Have Lost, London 1971 (2nd edition); Idem & Wall, Richard (eds.), Household and Family in Past Times, Cambridge, 1972. Also, Wall, Richard, 'Leaving home and the process of household formation in pre-industrial England', Continuity and Change, 2, (1), 1987, pp. 77 - 101, here pp. 77 - 78, 81. For a broad discussion of the various definitions of 'family', see Lenz, Rudolf, 'Emotion und Affektion in der Familie der Frühen Neuzeit. Leichenpredigten als Quelle der historischen Familienforschung', in Schuler,

of society'.[3] By implementing such rigid boundaries of classification, previous historical studies of the early modern family have inevitably lost many of the subtleties of the meaning of 'family' and household.[4] This chapter will offer indications as to how such omissions can be countered.

Unless research has focused upon a particular family setting or viewpoint (as found, for example in studies of autobiographies and diaries), any reference to the role of the family in caring for the sick in the early modern period has customarily provided scanty specific information.[5] In-depth and specific studies such as Sandra Cavallo's 'Family obligations and inequalities in access to care (Northern Italy 17th and 18th centuries)' which challenge the traditional view of the early modern family's role in health care are unfortunately still the exception to the rule.[6] Studies of Germany (as indeed of elsewhere) have, to date, woefully failed to rise to the issues raised in the aforementioned article by Jütte. At most, the question is raised as to issues of obligation - such as, did children care for ageing parents? Quantitative demographic data is frequently used to provide an answer, or the family is mentioned in passing in a wider discussion of charity and medical provision.

In his study of the 'French Disease' in Renaissance Italy, John Henderson commented that the confraternity which established the *Ridotto* in Genoa 'saw the hospital's clientele as distinguished from most other categories of the poor, for, as the statutes argued, these people were unable to earn a living, and furthermore, on account of having the gravest and longest-lasting infirmities are abandoned by everyone'.[7] Similarly in a 1500 report of the administrators of the

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Peter-Johannes (hrsg.), Die Familie als sozialer und historischer Verband: Untersuchung zum Spätmittelalter und zur frühen Neuzeit, Sigmaringen, 1987, pp 121 – 146, here pp. 126 – 129.

[3] Lombardini, Sandro, 'Family, Kin, and the Quest for Community: A Study of Three Social Networks in Early-Modern Italy', The History of the Family, Volume 1, No. 3, 1996, pp. 227 - 257.

[4] Tadmor, Naomi, 'The concept of the household-family in eighteenth-century England', Past & Present, No. 151, May 1996, pp. 111 – 140, here pp. 112 – 113, 132 – 135.

[5] Regarding autobiographies and diaries, see Beier, Sufferers; Lachmund, Jens & Stollberg, Gunnar, Patientenwelten: Krankheiten und Medizin vom späten 18. bis zum frühen 20. Jahrhundert im Spiegel von Autobiographien, Opladen, 1995. In-roads are slowly being made into this field. See especially Horden & Smith (eds.), Locus.

[6] Cavallo, 'Family'.

[7] Arrizabalaga, Jon, Henderson, John, & French, Roger, The Great Pox. The French Disease in Renaissance Europe, New Haven & London, 1997, p. 147.

Ridotto, the request for assistance from the governor of Genoa was attributed to the following discovery: 'many who are ill, labouring with incurable diseases, crushed by extreme poverty and misery and lying on the ground are to be found... Of these, some are abandoned by their neighbours and sons and wives because of the great violence of the disease and depth of poverty; others by their own parents; others by their friends and relatives...'.[8] Obviously the Italian situation differed greatly from that of Hesse. The illnesses with which we are primarily concerned are incapacitating conditions such as lameness, blindness, frailty, epilepsy and the like. Many of these stemmed from accidents or previous illnesses. Many applicants had suffered for a considerable period of time prior to their application for entry into the hospital. At its most fundamental level, however, the process of abandonment and desolation was the same. This chapter will go someway to explaining the process by which the locus of care broke down.

This thesis seeks to break away from these historiographical traditions in a number of important ways. Through the medium of the Haina and Merxhausen petitions, we will offer a subtler analysis of the way in which early modern people understood terms such as 'family' and 'household', showing the existence of a wider kin network than has hitherto been acknowledged in issues of medical care. Key aspects of family care which will be considered include an investigation into the identity of the carers and a related discussion as to what these results indicate regarding the conception of the 'family' and the 'locus of care' in this period. Through an analysis of the patterns of obligation that emerge in the Hessian sources, this chapter will focus upon notions of care, concern and emotion (alongside the connected themes of family, kinship and neighbourliness) as they were understood by the labouring poor. Rather than restricting ourselves to a consideration of the network of support that was available to a chronically sick individual, we will also consider what it would have been like to be a 'carer' in this period – an issue which has been largely ignored in historical studies to date. This will facilitate an assessment of the effect that the presence of a sick family member could have upon the household

[8] Idem, p. 148.

unit. In brief, how did a family and community cope with the presence of a chronically incapacitated individual?

II. Who cared? Household structure and support networks.

The nature of the petitioning process records the ultimate breakdown of a care network outside the hospital. Applications to the Hessian hospitals were only considered - both on the part of the authorities and, I would argue, the petitioners - as a last resort, when all other means had failed. The reader is effectively offered a view of a familial and communal care network that has collapsed. Nevertheless the autobiographical detail offered in a large number of the sources evidence an extensive range of care prior to a petition being lodged. This is particularly interesting given the length of time that an individual had been labouring under an illness prior to requesting institutionalisation.

Many of the petitions feature a seemingly 'traditional' household set-up, such as parents who care for their offspring, and one spouse caring for another. Other cases – a surprisingly large amount when compared to the findings of other historiographical studies - relate to wider kin such as in-laws (especially sister-in-laws and brother-in-laws), grandparents, nieces and nephews and cousins. Admittedly little detail is offered in some instances other than to state the relation of the petitioner to the invalid. Irrespective of the date at which they were written, some petitions offer little other than the most basic information. Sometimes it is unclear whether the information has been lost or was simply never written down – references are occasionally made to verbal petitions. In 1700, for instance, Johann Henrich Nippel, a dyer from Bobenhaußen in the district of Ulrichstein requested that the stepsister of his deceased wife be taken into Merxhausen.[9] No other detail is offered. Slightly more information is imparted in the 1703 correspondence of the brothers Hannß [sic] Simon and Johann Adam Weber. They asked for their stepfather Michael to be taken into

[9] LWV, Bestand 17, Reskripte, 1700. For examples of the bond between step-siblings, see Crawford, Patricia & Gowing, Laura (eds.), Women's Worlds in Seventeenth-Century England. A Sourcebook, London & New York, 2000, pp. 226 – 227.

Haina. Michael suffered from the 'falling sickness' and he was portrayed as a man who was 'completely impoverished and who was unable to feed (*ernehren*) himself, but must instead beg for his bread'. It would appear that the Landgrave was as dissatisfied as the historian with the amount of detail offered in the latter documentation, and he requested further investigation to be carried out.[10] Such brevity is not solely explicable in terms of extended families. The surviving sources for the 1698 case of Daniel and Rieus Nickell from Lippoldsberg merely mentions their insane (*verstandloß*) and impotent sister, but gives no details regarding her prior care.[11]

Brief references to family structure are in themselves useful in pointing to the resources of assistance that a person could hope to obtain. Even if we take the most sceptical view and argue that these persons were applying for their sick relatives so that they would be saved from the burden that they represented, this indicates a subliminal notion that some form of inter-familial care should exist. This was also true among complex family patterns, suggesting that the notion of 'family' was, in these instances at least, much wider than we may have imagined. In 1632 for instance Henrich Weber and Johannes Veit petitioned on behalf of their foster son (*Pflegsohn*) Andreas who suffered from some type of 'fearful sickness' (*scheülichen seüche*).[12] In 1696 Ludtwig Landtsiedell (from Schencklengsfeldt, district of Landeck) applied for his brother's widow whom he described as 'completely nonsensical (*unsinnig*)' and a danger to herself and the community.[13] Some cases suggest that co-residence was not the only indication of familial assistance. In 1580, for instance, Henrich Herker from Dornholzhaussen petitioned that his 'frail' brother-in-law be taken into Haina hospital. Both men resided in the same village, and Henrich's relative suffered from 'falling sickness'.[14]

[10] LWV, Bestand 13, Reskripte, 1703.
[11] LWV, Bestand 17, Reskripte, 1698.
[12] LWV, Bestand 13, Reskripte, 1632. (district of Battenberg).
[13] LWV, Bestand 17, Reskripte 1696.

i. Stepfamilies and '- in-laws'.

Perhaps the most interesting instances of care concern complex family relationships that have resulted through marriage – most notably stepfamilies and 'in-laws'. In her study of eighteenth century Bristol, Mary Fissell concluded that 'a family's obligations to its members was fairly limited. For instance, stepparents were not expected to be responsible for children from previous marriages.'[15] In contrast, the Hessian petitions reveal a high degree of family help prior to requesting institutionalisation. The affection felt amongst stepfamilies is often apparent. [16] In the case of step-children in particular, it would appear that, had the individual's infirmities not made them too much of a burden, the step-parent would have continued to care for them. It is clear that in some instances the support of an invalid step-child had carried on after the death of the natural parent.

While cases involving stepchildren applying on behalf of their stepparents do exist, the opposite action appears more frequently in the petitions. (Overall, it was also more common for parents to apply for their offspring than the other way around.) Concern for a stepchild is evident in the 1662 documentation relating to the stepson of Johannes Mauß, from Hatendorrf in the district of Neukirchen. A widower, his wife had left him with a son from her first marriage. Approximately eighteen years of age, the 'child' was partially mute, partially out of his mind (*verstandloß*), and reliant on his stepfather to support him. The latter was concerned that should he die, his charge would have no means to provide for himself. Johannes had obviously given this matter much thought for he stated that there were also no friends of his step-son's mother and father, who would be able to take him in under such circumstances.[17]

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[14] LWV, Bestand 13, Reskripte, 1580. The application was successful, and the 'young lad' entered Haina on 6 February 1580.
[15] Fissell, 'Drooping', p. 43.
[16] Compare to Lenz, 'Emotion', pp. 143 – 144.
[17] LWV, Bestand 13, Reskripte, 1662.

Other examples illustrate the continual drain on resources that long-term care of an individual implied. A report from the widow of Hansen Boden from Florshain in the district of Ziegenhain detailed that she had been left, wholly without means, with two children to care for. The eldest of these was five years old. Her stepson (apparently the five-year old) was 'completely dumb and without reason' and there was no hope that he would be able to support himself in the future through any form of manual work (*handtarbeit*). The only means that she had was in the form of an inheritance of approximately seventy *gulden* that had been left to the boy by his late mother. The widow was willing to donate this sum to Haina on the condition that her stepson was admitted to their care.[18] Clearly she considered that in the long-term it would be a better investment (presumably for both the boy and for her) to give this money to the hospital rather than to care for him herself.[19]

Concern for relatives through marriage is evident in the petitions. This includes the full spectrum of relationships, such as individuals applying for their brother- or sisters-in-law, and mothers- and fathers-in-law requesting for the admission of their sons- or daughters-in-law. The reverse of the latter also applies with pleas being made for fathers- and mothers-in-law. The documentation relating to the elderly Johannes Becker (as mentioned in Chapter Four) reveals that his son-in-law, Jacob Ledemann, had previously taken him in. The relative's financial situation was however similarly perilous to that of Johannes and he was therefore unable to continue to offer Becker shelter.[20] The implication is that these persons were considered to be an integral part of the family unit and were as eligible for care as a person's blood relative. In 1707, for example, Andreas Peter Grundellfënger from Cassel [sic] wrote to the Landgraves regarding his sister-in-law (Anna Dorothea Pfenning) who suffered from 'the falling sickness'. Anna Dorothea had been living with the Grundelfënger family. The report from the officials is particularly interesting and reveals much about the importance of 'seeing' and 'appearance' in medical diagnosis in this period. They commented that the woman appeared, 'on the outside', to be a 'young and strong person'.

[18] LWV, Bestand 13, Reskripte, 1641.
[19] For similar examples outside Hesse, see Demandt, Siegener, p. 100.
[20] LWV, Bestand 13, Reskripte, 1727.

She was however 'wholly weak and wretched in reason (*armseelig ahn verstandt*)' and suffered from severe epilepsy. They feared that she may have an accident with either fire or water, and requested that she be taken into the hospital as she would be 'better kept / incarcerated [*besser verwehret*]' there.[21] Access to an extended familial support network could continue even after the death of a blood relative. In 1722, the 'frail, seventy-year old' widower, Ludtwig Schröder, applied for Paul Seidler, his mute and lame son-in-law, to be taken into Haina. Schröder's physical state made him unable to care for this man. He clearly still felt in some way responsible for him however, in spite of the fact that his daughter (Seidler's wife) had died approximately six months earlier.[22]

ii. Grandparents.

Applications from grandparents feature throughout the period in the surviving documentation. In 1580, Merkell Peters from Lohlbach requested that her orphaned grandchild be taken into Merxhausen. Her own impoverished state meant that she was unable to support her three-year old granddaughter. She thus requested that her relative be cared for in the hospital until she was old enough to support herself through work.[23]

Military service seems to have been responsible for many of the complex family patterns evident in the sources and frequently explains the presence of grandparents as the primary carers. The 1704 application of Annen (variously spelt 'Anna'), the eighty-year old widow of Bartheldt Reinhardt is indicative of this care network. Annen requested that her sixteen-year old infirm (*gebrechlich*) granddaughter be taken into Merxhausen. The girl's father (Annen's son) had been killed in military service. Further reports from various officials reveal that the granddaughter had suffered from smallpox (*blattern*). This had damaged her eyesight, rendering her blind. Her father had been a shepherd in Verna. Following his wife's death, he had left his children (presumably in the care of

[21] Ibid, 1707.
[22] Ibid, 1722.
[23] LWV, Bestand 17, Reskripte, 1580.

their grandmother, although this is not stated) and had embarked on military service. The correspondence of the pastor and of two local governors (*Vorstehers*) stated that, as far as they have been able to ascertain, neither the girl's father nor her mother had left her any inheritance. Her physical condition meant that she was unable to provide for herself. Her grandmother was presumably also unable to offer assistance any longer. (As no dates are given regarding the above events, the level of care that this relative had offered in the past is unclear.)[24]

Grandfathers also feature as carers, reiterating the point that 'caring' was not a solely female preserve. In 1710, for instance, Hans Wilhelm Muller, a poor day labourer, applied for the admittance of the son of his deceased son-in-law. (He latter calls this boy his 'grandson', possibly indicating the partial tendency to speak of children in terms of their paternal parentage). The latter was a mute boy aged ten years. His late father, Johann Henrich Dietmar, had been at a camp near Orchie in the post of army captain when he died. He had spent twenty-eight years in military service. Correspondence from the military authorities confirmed that he had died in 1709, as a result of 'an illness'. His wife (Hans Wilhelm Muller's daughter) had died six years previously, leaving 'six father- and motherless orphans', including the boy in question. Muller described himself as a poor former soldier, and explained that he had been able to support his grandson for some time and keep him 'in food and drink, clothes and shoes'. He was however unable to carry on with this action. In his widowhood, he was 'rarely able to earn his bread' and could not provide sufficient long-term sustenance for two persons.[25]

[24] Ibid, 1704.
[25] LWV, Bestand 13, Reskripte, 1710.

iii. The wider 'family': friends and guardians.

Patterns of care extended outside the family not just to the community per se, but also to close friends of the parents – as previously alluded to in the 1662 correspondence of Johannes Mauß. The 1715 petition from Johannes Mötzing and Georg Zien from Wiedershaußen is also indicative of this. The men explained that 'six years previously ... a married couple, with whom they were great friends (*nahe befreundet*) died and left behind two sons who were without understanding (*unverständige*) ~~sons~~, the first of whom is [now] twenty-seven and the other is [now] twenty-one years old'. Both of these persons were also deaf and mute. The eldest 'crawls on his hands and knees'. The deceased parents had left 'few means' for their sons' upkeep. As a result of this, Mötzing and Zien were unable to care for the brothers any longer, and they explained that no one else wanted to take them in. The records show that both brothers were received into Haina on the 24th September 1715.[26]

Applications from guardians also appear. In 1615, Paul Muller and Sebastian Schaffer, guardians of the infirm (*presthafftig*) son of the late Bast Weußen from Weiches appealed for the latter to be granted admission to Haina. Without the necessary strength to enable the performance of any form of work, their impoverished charge could not support himself. Unable to go into any form of service, he was (in theory at least), granted a place in the hospital. It appears that in the case of children who effectively required life-long 'guardianship', the prospective guardian could look to the state to take over their role, and provide an alternative type of 'family' - in this case, within an institutional framework.[27] This state of affairs can be compared to that which Micheline Baulant has discovered in early modern Meaux, France, whereby, even (it would appear) if the offspring were healthy, the 'function [of guardianship] seemed an unbearable burden to many'.[28]

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[26] Ibid, 1715.

[27] For the variability in the meanings and functions of guardians and *Pflegers*, see Sabean, David Warren, Kinship in Neckarhausen, 1700 – 1870, Cambridge & New York, 1998, especially pp. 23 – 34, 98; Idem, Property, Production and Family in Neckarhausen, 1700 – 1870, Cambridge & New York, 1990, pp. 197, 252, 407, 414, 424.

[28] It must be noted that Baulant is not concerned with issues of health and sickness. Baulant, Micheline, 'The Scattered Family; Another Aspect of Seventeenth-Century Demography', in

We should be wary of assuming that the presence of the term 'orphan' always denoted a person whose mother and father were deceased. As David Sabean has found in Neckarhausen, it was common for a child to be referred to as an orphan when the mother was still living.[29] Nor did the presence of a guardian necessarily mean his charge was without other family who could potentially be called upon to care for him or her. This is revealed in the 1716 documentation relating to Peter Heinemann, the guardian of Peter Zusche.[30] The application to Haina was prompted by the 'infirm condition' (*gebrechliche Zustandt*) suffered by Zusche, a 'fatherless orphan' from Eschenstruth. We learn from the officials' report that the invalid was 'approximately 19 years of age'. His present mental and physical state was blamed upon a childhood accident – he had fallen out of a high window onto a street, and had hit his head. From this time onwards, he had been frail, of ill health and lacking in understanding (*unverständig*). He was consequently incapable of working. Proof of his condition lay in the fact that he had had to quit his former service with his cousin (*Vetter*), Clobus Hohmann. He had held this position for two years - suggesting perhaps that his condition had progressively worsened since the accident. Zusche's father, Jonas, had died eleven years previously. His elderly mother was completely blind, and Zusche had a twenty-two year old brother who was in the service of a local official (*Grebe*). The family had a small house with some enclosed land. This included two small barley plots [*weisen platze*] and a small plot of garden. They had accumulated some debts, but the eldest son was still able to earn some form of wage and contribute in some way to his mother's upkeep. Peter Zusche was admitted into Haina in April 1716.[31]

All of these varieties of 'family units' suggest that it is not merely among the upper classes that such broad support networks were formed. It would appear that a similar process is occurring to that which Kristin Gager has unearthed in her study of adoption in early modern Paris. Namely that, as Gager states, 'ties of spiritual, affinal, and consanguineous kinship formed strong and enduring bonds

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Forster, Robert & Ranum, Orest (ed.), Family and Society Selections from the *Annales, Economies, Sociétés, Civilisations*, Baltimore & London, 1976, pp. 104 - 116; here pp. 108 - 109.

[29] Sabean, Kinship, p. 29.

[30] Variously spelt: *Zuschen, Zusche, Zusch.*

for artisan and laboring families, ties that ensured the intervention of kin in critical moments for some families'.[32] At the same time, however, evidence also suggests that a framework is present which is comparable to that unearthed by Sandra Cavallo in her aforementioned study of early modern Turin. Cavallo discovered that 'many domestic and kinship groups were unable to shoulder the burden of providing for their aged and infirm relations', and that those 'who sought admission were often not without living offspring and kin', who might even be living nearby.[33] I now wish to consider some of the reasons why these two phenomena may have occurred, as suggested by the hospital petitions.

III. The breakdown of the care network.

i. Inter-generational poverty.

The overwhelming role played by poverty should not surprise us given the admissions criteria of the *Landesspitäler*. A crucial factor that attributed to the breakdown of (or the unfeasibility of) a care network is located within inherited poverty. In short, the children of beggars themselves became beggars.[34] This issue was succinctly summarised in 1710 by Anna Catharina Käeßin (also Käsin) when she lamented that her father had left the family with no inheritance other 'than his honourable name'.[35] (It must be noted that this latter reference reveals the importance of honour as a tradable commodity.)

A typical example of the problem of the trappings of poverty, whereby the offspring of paupers are themselves poor, can be found in the 1629 case of Stoffel Cramer.[36] A widower from Heußen, in the jurisdiction of Ebisdorff, he was elderly, blind and infirm (*gebrechlich*). Previously he had maintained himself as a 'cow-herd and shepherd, in particular in this district of Ebisdorff'.

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[31] LWV, Bestand 13, Reskripte, 1716.
[32] Gager, Kristin Elizabeth, Blood ties and fictive ties: adoption and family life in early modern France, Princeton, New Jersey, 1996, p.92.
[33] Cavallo, 'Family', pp. 94 – 95.
[34] Compare to Huppert, George, After the Black Death: a Social History of Early Modern Europe, USA, 1998, p. 103.
[35] LWV, Bestand 17, Reskripte, 1710.

Roughly a year before however he had been struck by blindness. As a result he was no longer able to work. A poor man, entirely without means other than that which he earned through his work, Stoffel's present physical condition had tipped the balance sufficiently for him to be unable to sustain himself any longer. Hence the petition. The accompanying reports reveal that Stoffel had been a cowherd in this area for more than thirty years. He owned no property and was a widower with two children. Unfortunately none of his offspring were in a position to support him. One of them was reduced to begging. The other was maintained by his maternal aunt, and was described as 'very probably...a poor man, as the supplicant [his father] is'.[37]

In some cases finance was only one issue. Some families had clearly been plagued by misfortune. According to the 1702 correspondence of Elisabeth, widow of Conrad Heßen from Unterhaußen in the jurisdiction of Ebsdorff, she '[has] eight living children ... of whom one son has been away at war for twelve years, [and] two daughters ... one [of whom] is twenty years of age and the other twenty-two years, [who are both] quite miserable [*elend und miserable*].' The twenty-year old girl had lost her sight seventeen years before as a result of smallpox (*blattern*) and was now completely blind (*stock blind*). Her older sister had been lame for the past twelve years and was forced to use crutches to move about. Their mother described herself as a 'decrepit', 64 year-old woman, who was no longer able to support herself. She thus requested that her blind daughter be taken into Merxhausen.[38] This case is particularly interesting. The records reveal that the mother had initially requested that both her daughters be admitted into Merxhausen, but the application for the lame girl was later crossed out. Quite why this was the case is unclear. It may well be that it was deemed detrimental to the petition to make this double request. Were this the case, it might be that a hierarchy existed among the bodily states whereby a lame person was deemed more likely to be able to survive in the outside world than a blind one. Unfortunately we can only speculate upon this matter.

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[36] Also spelt 'Krämer'
[37] LWV, Bestand 13, Reskripte, 1629.
[38] LWV, Bestand 17, Reskripte, 1702.

The petitions reveal the frequency with which children followed their parents' employment pattern. Moreover, the offspring of the poor usually married into families of similar economic standing. Both factors are evident in the 1709 Haina petition of the elderly and impotent (*gebrechlich*) Ostwaldt Heinemann from Quentell. The report of the Liechtenau officials related that Heinemann was 'at least [*zuvorderst*] seventy-five years old'. Approximately thirteen years previously he had had an accident whilst working as a carpenter in Groß Allmeroda. He fell from a roof and broke three ribs. He also had an axe fall on his hand – no other details are offered. Both accidents were deemed to be so serious that on both occasions he was feared dead. Although the applicant had, to date, tried his best to work alongside his son, who was also a carpenter, his advancing years and physical frailties had rendered this option untenable. Heinemann was wholly without means, owning neither a house nor any land. He had hitherto been living with his son-in-law. The latter was 'a travelling ditcher / waterman [*Waßerhäger*] and as a result was seldom at home'. Presumably this factor prevented him from providing Heinemann with the care that he required. Heinemann's son-in-law was similarly impoverished, and was described as having 'nothing *in bonis*'. Long-term support of his father-in-law would thus prove impossible. His family members were able to support themselves, but the precarious economic balance of their lives would not sustain another person. The local authorities deemed their application to be 'of the highest necessity'. The Landgrave and hospital officials evidently agreed with this summation and Heinemann entered Haina on 3rd July 1709.[39]

Other instances reveal the problems inherent in an individual's retirement failing to match up to the expected standard. This usually finds its expression in cases whereby a person has handed their children their inheritance with the understanding that the latter will provide for them (the parents) in their old age. For a variety of reasons, in this scenario, the benefactor accumulates debts and frequently loses the property bequeathed to them. They are barely able to support themselves and are wholly unable to keep their promise to their aged parents. Such misfortune is evident in the case of Christoph Färber from Lohra, in the

[39] LWV, Bestand 13, Reskripte, 1709.

district of Felßberg. Documentation from 1722 describes Färber as seventy-two years of age and as suffering from great poverty. Both the supplicant's and the local officials' reports stated that Färber had previously held 'a farm that was liable to tax in money and services [*dienst- und contributionsbaren ackerhoff*]' in Lohra. Approximately fifteen years previously he had 'given over these ... possessions' to his son Johann Henrich Färber with the understanding that the latter would then provide for him. Various misfortunes had since befallen his son. (According to officials the latter had not managed the property well). He had accumulated many 'passive debts'. As a result, Färber's son had been forced to give up this land a few years previously in order to pay off his debts to a variety of creditors. Färber had thus become 'a poor, old, decrepit man' without a place to live nor any form of care or food. His 'high old age and impotence' had rendered him deaf and blind. Described by officials as 'one of the oldest men in the district', Färber now found himself forced 'in his old days' to suffer 'in utmost poverty and misery'.[40]

ii. Poverty as a reason for preventing care.

Historians Peter Laslett and Alan MacFarlane have concluded that, in England, parents were never certain of the support of their children and, as a result, the wider community had long acknowledged its responsibility for the aged poor.[41] Historians have also extended this lack of care to siblings. Mary Fissell has concluded that 'the responsibilities of siblings to each other were ... fairly minimal.'[42] Contrary to the theoretical notion that an individual's kin should be their first point of call, the reality of the situation was as Jütte has described: 'in some cases overseers and magistrates found it as important to prevent the fulfilment of kinship obligations as to insist upon them.'[43] Similar motivations can be found in the Hessian petitions. In a 1710 Merxhausen case relating to the

[40] Ibid, 1722. He was received into Haina at some point during this year.
[41] MacFarlane, Alan, Marriage and Love in England, Oxford, 1986, pp. 105 – 106; Laslett, Peter, Family Life and Illicit Love in Earlier Generations, Cambridge, 1977. Regarding the individualistic nature of English society that Macfarlane advocates, see his The Origins of English Individualism, New York, 1979, pp. 131 – 164; also Idem, Marriage, pp. 321 – 344.
[42] Fissell, 'Drooping', p. 43.
[43] Jütte, Poverty, p. 88.

poor, lame and impotent Eliesabeth Umbach from Metza, the report of the local official indicated that it was well known that she had grown-up children living in the village. The poverty of her offspring was deemed to be such that they would have had enough of a struggle to support themselves.[44] It seems to have been accepted that they would therefore be unable to take on the added burden of their mother, for this fact is not stated but merely implied.

But do these petitions solely reveal a lack of care and support between families? By their very nature, these are instances in which the network has failed but as previous examples have revealed they often reveal an earlier struggle to provide assistance. Such factors are not solely the provision of Hesse. For instance, in the 1620s when Barbara Ziegler from Bächlingen in south-west Germany was admitted to the local *Spital*, she explained: 'I stayed with my son for four years, but the food was bad and [he] supported me only with great effort'.[45]

Poverty was the primary factor for rendering family care untenable. A late sixteenth century petition from Thebes Kalckbrenner from Weissenborn in the jurisdiction of Auela [sic], serves as an early example of these problems. Thebes described himself as a 'poor old man' who had been forced to support himself through hard manual labour throughout his whole life. His increased weakness and incapacity meant that he was no longer capable of fending for himself. A widower, he had lived with his son for several years. The latter was similarly a poor man who relied upon his capacity to work to feed himself. Thebes revealed that his son's own economic situation meant that he had enough to cope with, and he could no longer afford to take on the extra burden of his father. Thebes explained that he was forced to endure 'a great shortage of food and clothing' and must 'suffer the frost'. He thus requested that he be taken into Haina and be cared for therein.[46]

Financial considerations also explain both the impossibility of – and the breakdown of - sibling assistance. The 1627 documentation relating to Georg

[44] LWV, Bestand 17, Reskripte, 1710.
[45] Robisheaux, Rural, p. 162.
[46] StAM, Bestand 17I, Nr. 5116.

Schmidt was written on his behalf by the 'poor subjects of the village of Eschenroda, the mayor and the whole community (*Gemeinde*)'.[47] The son of the late Steffan Schmidt, Georg suffered from epilepsy (*die schwere Noth*). Following his father's death, Georg had supported himself through farm service, but this did not work out. Epilepsy had plagued Georg for quite a number of years and had affected his mental state, rendering him imbecilic (*blöd*). The latter condition frequently necessitated his restraint, with neighbours assisting to 'watch over him'. His siblings - including step-brothers and -sisters - were themselves impoverished, most of them also being in farm service. They were therefore unable to care for him and he had become the responsibility of his neighbours.[48] This latter point serves as a good indication that the community was expected to care for an invalid before a petition could be registered. The chain of responsibility ran from the immediate to the extended family and then to friends, guardians and foster parents. If all such networks failed, the local population was expected to take over. Only once all of these resources had been exhausted could an application be submitted.

Sources relating to Jost Fröhlich from Dörnberge [sic] indicate that he was 'a poor lame and quite impotent (*gebrechlich*)' man who suffered from 'matchstick [*scheiben*] legs'. His limbs were disfigured by some form of curved growth that had formed 'a hump on the vessels of his feet [*fueßröhren*]'. He was dependent upon the charity of others to survive. His remaining family included a brother named Ludicke and a sister, Anna Fröhlich. The former was a 'poor day labourer' who relied upon his daily wage to provide for his children. His sister was 'a poor female who lived from the proceeds that she earned from begging [*bettelbrodt*]'.[49] Clearly neither of these relatives were in a position to take on the extra burden of their invalid brother.

Parents were sufficiently realistic to realise that their impoverished offspring would be unable to look after a chronically ill sibling after their (the parents') death. Such evidence can be found in the reports of Georg Warnecke, a widower

[47] Also spelt 'Schmiden', Schmiede'.
[48] LWV, Bestand 13, Reskripte, 1627.
[49] Ibid, 1698.

from Bruckhasungen.[50] Primarily concerned about the fate of his daughter in the event of his death, he described her as 'a poor girl of sixteen years of age' who had been 'born mute' and had 'not the slightest bit of strength in her limbs'. While it was his responsibility to provide for her until his death, he was well aware that after his demise she would be wholly unable to provide any sort of income for herself. In addition to this daughter, he had seven remaining 'motherless children'.[51] Clearly he did not expect them to care for their sister in the long term. Similar concerns are evident in the following century. Documentation from 1721 records Christoph Hoppe's concern for the fate of his epileptic and mentally impaired son. Christoph was now in his second marriage. His family had 'a total of six children' and he believed that his 'death was fast approaching'. As a poor man whose offspring would be forced to work for their upkeep, Christoph was concerned that 'should I his father die, this [would] leave my stupid [*blöder*] son quite desolate and without all help'.[52]

iii. The dilemma of familial allegiance.

The aforementioned narrative of Jost Fröhlich touches upon a central question in many of the petitions: family allegiance. With whom should one's primary loyalties lie, with one's birth family (including parents and siblings) or with one's immediate family through marriage (spouses and children)? In the documentation the answer invariably lies with the latter group. Similar policies have been found elsewhere. In her study of old age in England, Pat Thane concluded that 'there was a strong sense of obligation to give what material and emotional support one could to elderly relatives, within reason – but not so as to drive oneself and family into destitution. The obligations of married sons and daughters were first to their spouses and their children and only secondarily, if they had resources to spare, to their parents'.[53] The examples cited here reveal that this prioritisation did not restrict itself to cases involving the elderly. Neither

[50] Also Burghausungen.
[51] LWV, Bestand 17, Reskripte, 1635.
[52] LWV, Bestand 13, Reskripte, 1721.

should we be surprised by this factor. After all, logic must have dictated that enforcing an already impoverished family to take on the double burden of not just another mouth to feed, but also one which would only drain the household resources (rather than make its own contribution to it) would be sheer folly. It would push the whole household over the boundary line into desperate poverty and the state or community would be forced to step in and assist an entire family rather than just the one person.

A fairly typical illustration of the question of allegiance and duty can be found in the 1698 petition of Johann Jost Rinck, the miller at 'Closter Haÿna [sic]'. His parents had earlier worked in the same mill for forty-two years. Upon his father's death some years previously, Johann had taken over his father's role and had worked with and cared for his mother. He explained that this arrangement could not continue any longer. He had married the previous year and commented that 'the bread and food that we receive is only intended for two people'. Their family unit had grown to three, but the provisions that they received had not increased accordingly. As a result, his mother, 'in her advanced old age', was forced to suffer shortages. Moreover, Johann stated that his yearly salary was so meagre that it could barely support himself and his wife. Interestingly enough, instead of asking any form of pay rise, he merely requested that his mother be taken into either Haina or Merxhausen for the short time that is remaining of her life.[54] Clearly Johann believed that his primary concern should be for his newly formed family unit. The community and authorities agreed with him.

Similar arguments are also used in cases of sibling responsibility. In 1696 Hanß Henrich Simmen requested that his brother Michaell [sic] be taken into Haina. The latter was a former soldier aged thirty-two years. He was 'wholly lame in his hands and feet', had lost his sense of reason (*ohn Verstand*) and simply lay in bed. Further documentation recorded that this man had been dismissed from military service at the beginning of 1696 as he was deemed 'incapable'. It would appear that this was not the first time that he had been incapacitated. He was

[53] Thane, Pat, 'Old people and their families in the English past', in Daunton, Martin (ed.), Charity, self-interest and welfare in the English past, London, 1996, pp. 113 – 138, here p. 134. Regarding children and the elderly, see also Idem, Old, pp. 136 – 137, 140 – 145.

described as having always been 'a very weak and infirm person' who had mental problems. After he was released from military service he had been forced to make his own arrangements for returning home to his brother's house. For the past few months he had resided with this relative and had proved (through his inability to raise himself from his bed) a constant drain on the family's limited resources. Hanß Henrich explained that as 'a poor man with five small small [sic] children' who had 'nothing in the world other than what [I] earn through manual labour' it was impossible for him to support his brother any longer. He was clearly not denying his responsibility for his sibling's care, but felt that his circumstances rendered it an impossible aim. The authorities clearly agreed with this summation.[55]

iv. The disruptive effects on the wider household.

Poverty was not necessarily the only factor. An inability to cope with the situation and consideration for the family unit as a whole were other factors that came into play.[56] A 1605 report from Catherina, wife of Henrich Jungens from Grossenhaußen regarding her sister-in-law offers insight into the problems of balancing the care of a relative against the care of your immediate family - especially in the case of mental illness. Her sister-in-law, Elsa, had lived with their family for the past two years. They had hoped that she would recover from the mental afflictions which had left her 'witless' and 'simple' (*unwitzig* and *einfaltig*). The petition had been prompted by her anti-social behaviour – she was variously described as 'coarse', 'indignant', 'awful [*arg*]' and 'angry [*bös*]'. Her actions had particularly effected the children and the household in general – the latter group included servants [*gesindt*], suggesting perhaps that this was not a particularly impoverished family. As in other cases relating to mental illness, the potential 'danger' that an individual's condition represented overrode

[54] LWV, Bestand 13, Reskripte, 1698.
[55] Ibid, 1696. The invalid is also referred to as 'Michel Simon'.
[56] For a modern take on the tensions that can occur within caring, see Qureshi, Hazel, 'Responsibilities to Dependency: Reciprocity Affect and Power in Family Relationships', in Phillipson, Chris, Berntard, Miriam & Strang, Patricia (eds.), Dependency and Interdependency in Old Age. Theoretical Perspectives and Policy Alternatives, London & Sydney, 1986, pp. 167 – 179.

considerations of poverty. Elsa entered the hospital on 3rd February 1606, bringing 155 *Reichsthaler* with her.[57]

Epilepsy was another medical condition that could render a person socially unacceptable. A 1695 report from Merxhausen relating to Ann Else, the 'poor miserable pious and desolate (*verlaßene*) orphaned daughter of Johannes Caspar illustrates this point. (It also serves as an important reminder that the term 'orphan' was not solely confined to children – Ann Else was forty years of age.) God had 'afflicted her' with a stroke. As a result she was rendered lame on her right hand side, and was unable to support herself through work. She also suffered severely from *morbo epileptico* to the extent that she 'was forced to lay for almost the whole day or night in misery'. As a result of her afflictions she was also unable to beg and could find no other means of lifting herself out of her poverty. Up until now she had relied upon her step-sister for support. This relative's actions towards her were described as a 'work of compassion'. 'She had tolerated and provided for [*verpfleget*]' Anna Else for a considerable period of time but was unable to maintain this support any longer. The principal reason behind this was her children. The *affectus epilepticus* and Anna Else's aggressive behaviour were felt to be potentially detrimental to the youngsters, as well as being a general threat to all. Her step-sister had apparently not taken this decision lightly for she is described as approaching the officials' with her request with 'tearful eyes [*mit leyd thränden augen*]'. Concern for her own family took precedence however.[58]

Certain diseases appear to have been considered anti-social, and the sufferer was left bereft of any additional source of care In the 1579 petition of Walpurgis, the wife of Hermann Luzen from Hanau, they referred to the plight of their daughter who was suffering from epilepsy (the *schweren plage*) and cancer. The former illness was also referred to as 'lengthy' and her father explained that she was as a result, 'quite lame in the limbs'. She also suffered from cancer of the foot, 'which abominable illness' left 'the poor girl' incapable of earning her bread and also made it impossible to find anyone who would maintain (*underhalt*) her.

[57]LWV, Bestand 13, Reskripte, 1605.
[58] LWV, Bestand 17, Reskripte, 1695.

Concerned for the plight of her daughter and restrained by poverty in the amount of assistance that they (the parents) could offer her, Walpurgis applied for her offspring to be taken into Merxhausen.[59]

v. Mirrored impotence: the increasing incapacity of the carer.

The applications written by an elderly parent on behalf of their children reveal three main motivations for petitioning. In some cases the authors considered themselves unable to cope with their offspring's ailment because their old age prevented them from being able to continue to offer the same level of care. Alternatively the patient's condition had worsened to such an extent that the carer was unable to assist any longer, or, thirdly, the relative feared that they would soon die and wished to ensure that their child would be cared for in the future.[60] The widow of Dittmar Wilhelm from Obern Werba in the domain (*Herrschafft*) of Itter referred to this matter in her application to have her crippled eighteen-year old son admitted to Haina. She desired to see her son provided for (through his entrance to Haina) before she died. This wish stemmed from her 'motherly love and concern'.[61] Such sentiments were not the sole preserve of mothers. Neither should they be dismissed as mere rhetoric. Johann Jakob Aubel requested that his nineteen-year old son Ludwig was taken into Haina, stating that 'I ... grieving (*betrübte*) poor father would gladly see [this happen] before I die'. He described Ludwig as 'as very miserable ... [boy] full of infirmities, fluxes and misery, who was incapable of going into the service of anyone'.[62] Ludwig was admitted into Haina on 20th April 1740. Jacob's original petition was written in 1736. No details are offered as to what happened in the intervening four years, nor indeed whether Jacob was still alive at the time of his son's entrance into Haina.

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[59] LWV, Bestand 17, Reskripte, 1579.
[60] For a typical example of the increased problems of dealing with a mentally ill person in one's old age – particularly if they are increasingly violent or if they frequently escape and require 'chasing after'. See LWV, Bestand 13, Reskripte, 1721, Christoph Hoppe from Laudenbach.
[61] LWV, Bestand 13, Reskripte, 1710.
[62] Ibid, 1736.

An inability to cope any longer could be caused by the physical health of the carer. This was particularly evident in instances in which a person had been sick for many years, usually since childhood, and they had been cared for within the home, most frequently by their parents. Similarities also featured in cases in which one spouse asked for the other to gain admission to a hospital. In both such scenarios, the 'carer' had frequently become too old and frail to look after their charge any longer and they thus petitioned the Landgrave for entry to the *Landeshospital*. Some of these petitions requested the admission of both the 'carer' and the charge, but frequently it was only the latter. It remains unclear whether this was because the 'carer' believed that admission was more likely if only one application was made. This would signal a selfless act, whereby the 'carer' was more concerned for the welfare of their patient than for themselves. Alternatively the 'carer' might have believed that they could support themselves but could no longer cope with the physical strength required for caring. Further study is needed to ascertain whether a pattern can be formulated, whereby this type of application is related to certain illnesses which would require the carer to have a certain measure of physical strength. This would apply in cases of cripples, epileptics and people suffering from other physical ailments which affect movement in particular, and through which the afflicted could unwittingly harm themselves.

A report from Johannes Bergius, 'a poor, old and weak pastor' is a good example of this process. Written on 13th September 1627, Bergius' application is for his blind son rather than himself. God had sent Bergius a 'cross to bear' (*Hauskreutz*) in the shape of his son's condition. Being blind for eighteen years had rendered his son poor. 'Such a deficiency' had meant that he was 'unable to earn his bread'. The pastor had consequently been forced to support and feed his son for 'so many years', sustaining him on a 'very meagre income' and with similarly scant food provisions. (Significantly, the pastor noted that this state of affairs had disadvantaged and in some way 'damaged' his other children.) It had previously been suggested to the pastor that his son be taken into Haina. This offer was not taken up, for at the time they 'still had hope that he would regain his sight through God's help and through the medium of medicine, and [that he] would be

able to earn his own bread'. Furthermore the pastor had, at this point in time, still been active in his 'meagre (*geringe*) vocation', and was thus able to support himself through God's Word. Now however his advanced years, and the various physical weaknesses that 'God has sent' him had helped to convince him that, in his present situation, he must finally give up his son to the hospital. Having served as a pastor for thirty years (on a 'meagre wage'), he was now no longer able to earn as much as previously. As an elderly man, Bergius was concerned about the fate of his son when he (the father) died. The application to Haina was therefore motivated by this desire to see his son admitted to the hospital in which he will be cared for for the rest of his life.[63] In a sense, this is the only (and the most fitting) inheritance that he can provide for his son. An additional motivation might also be at work. Having had first-hand experience of the realities of caring for an invalid, the parent might have even more reason for not wishing to pass on this added burden of 'inheritance' to the rest of their children.

Bergius' correspondence offers important clues to the issue of 'emotion' within the petitions. Notions of emotion and familial love have notoriously been underplayed within early modern medical history.[64] In 1984, Hans Medick and David Sabean called for historians to consider more fully 'the dialectic between the public and the private moments of family life'.[65] This is particularly true in cases relating to emotion within documents such as pauper and poor relief petitions. Far from dismissing the depth of feeling evinced in such sources as mere rhetoric designed to impress officials, sources such as Bergius' reflect the truth of these sentiments. After all, had Bergius not truly cared for his son and lived in constant hope of his recovery, he would have taken up the earlier offer of assistance – particularly as he himself admitted he believed that the situation was putting a strain on family life. Clearly we should not unquestioningly accept

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[63] Ibid, 1627.

[64] Important studies including broad discussions of the history (non-medical) of emotion include Medick, Hans & Sabean, David, 'Emotionen und materielle Interessen in Familie und Verwandtschaft: Überlegungen zu neuen Wegen und Bereichen einer historischen und sozialanthropologischen Familienforschung', in Medick, Hans & Sabean, David (hrsg.), Emotionen und materielle Interessen: sozialanthropologische und historische Beiträge zur Familienforschung, Göttingen, 1984, pp. 27 – 54; Lenz, 'Emotion', pp 121 – 146. For earlier examples of parental grief, see Shahar, Shulamith, Childhood in the Middle Ages, London, 1990, p. 147. Also, Rosen, 'People'.

[65] Medick & Sabean, Emotionen, p. 41.

every piece of written evidence. Neither however should we blindly dismiss it all as a form of exaggerated linguistic bartering if we are to unearth the subtleties of family relationships in this period. The role of emotion in family life as a whole is a vast area that deserves further consideration.

IV. The importance of the care network.

Networks of care played a quintessential role in facilitating a chronically ill person's survival. Other forms of petitions that exist for the *Landesspitäler* offer a further indication of this. These hitherto ignored documents (*Bittschriften*) are essentially requests for aid from the *Landesspitäler* in the form of both sustenance (food, wood, and occasionally clothing) or, less frequently, money. Once granted, it would appear that these allowances became regular contributions being granted at regular intervals. In comparison to the petitions (*Reskripte*), far fewer of these early modern documents survive, but their existence poses important questions regarding the role of the hospitals in the lives of the sick poor. A crucial question – which can unfortunately not be fully answered in this thesis – relates to why some persons asked for this form of alms rather than for admission to the institutions, even though their conditions seemed similar to those petitioners requesting hospitalisation.[66]

One answer (although not the sole one) relates to familial aid. This is illustrated in the 1708 correspondence from Elisabeth, the widow of Jost Lingelbach from Obern Urff in the district of Borcken. Elisabeth had been widowed for the past decade and had been left with two small children. One of these was 'in a quite bad state' and had died young. Twelve years previously the other child had 'unfortunately fallen into a fire and had not only completely burnt himself, but as a result ... also had holes in [his] legs'. These 'holes' had failed to heal and it was therefore necessary to treat this child twice daily by administering some form of cool plaster (or bindings) to his legs to alleviate the pain. The implication is that she prepared these herself for they are described as being

[66] I plan to write at greater length about these sources in the future.

made from domestic ingredients (*Haußmitteln*). One of his arms and one leg had also 'disappeared [*verschwinden* - sic]' rendering him unable to move or indeed to do anything else. His mother was forced to carry him. The constant care and attention that her son required made it almost impossible for her to earn a wage. As a result they were frequently wholly without either bread or money and they were completely dependent upon the charity of others for their sustenance. Elisabeth applied to the superintendent, council and commissioners of the hospitals for some form of perpetual alms to support her son (and by implication herself). Her report was substantiated by local officials. The visitation committee ordered that the invalid should be granted 'eight measures (*Mesten*), or a Haina measure (*Muth*), of corn'.[67]

The exact reasons behind a petition taking the form of alms rather than hospitalisation are unclear, although in this case at least it would appear that the care provided by the mother was an important factor. Elisabeth clearly felt able to continue to care for her son provided that they had some way of ensuring that they received some sustenance. Given that many of the other petitions discussed above concern large families in which the invalid was one of many children, the fact that Elisabeth's son was an only child may also have had some bearing on the matter. At present conjectures can only be made.

The boy's age may also have been a factor – although this is a grey area that requires more research. Eighteenth-century cases exist which suggest that, provided that a child was not orphaned, it was sometimes deemed that he or she would be better served by remaining within the family than to be taken into a *Landesspital*. This belief explains the outcome of the 1728 petition of Johannes Winther, Corporal in Prince Friedrich's regiment, regarding his nine-and-a-half year old daughter. She had earlier suffered from smallpox (*blattern*) and was as a result 'completely blind [*stock blindt*]'. The usual concern about available vacancies was voiced by the Landgraves and the hospital authorities. Their main focus however centred around the question of whether she was 'still too young' to be a patient and, perhaps more importantly, whether Merxhausen had the

[67] LWV, Bestand 13, Bittschriften, 1708.

facilities to cope with the charge – was there someone available to offer the appropriate care for her condition? The final decision reached was that Winther's daughter should take over the assistance previously given to the (recently deceased) daughter of Johannes Umbach from Besa – suggesting both that this practice was more widespread than the hitherto unearthed surviving documentation would lead us to believe, and also that some form of quota was attached to such forms of assistance. The girl was to receive a yearly provision of two quarters of corn, two measures (*Metzen*) of wheat, four measures of barley and one of peas (*Erbsen*). She would also be eligible to re-apply for a place in the hospital at a later date.[68]

V. Conclusion.

The whole issue of the understanding of the early modern 'family unit' and of corresponding networks of care as evinced in the Hessian petitions reveals that this is a much more complex issue than has (all too frequently) previously been acknowledged by historians - and in particular by historians of medicine. Further research needs to be undertaken to ascertain whether this phenomenon is unique to rural Hesse – although I suspect that this is not the case. Factors such as poverty, the length of illness, and the ability of the invalid or the carer to cope, all intermingle to produce a situation that is far less formulaic and predictable than has previously been acknowledged. The Hessian petitions reveal a situation that is contrary to that propounded by Peregrine Horden in his work in family and hospital history in the Middle Ages. Horden advocated that: 'families, households, neighbourhoods, have a less dominant role than might have been expected from the assertions that historians customarily make. Informal welfare is vital, certainly. Yet it is not as capacious as it has been projected because pauper households are too small and pauper networks too fragile to sustain very much in the way of extra burdens.'[69] Although the Hessian petitions ultimately indicate the breakdown of such networks, they nevertheless reveal their

[68] LWV, Bestand 13, Reskripte, 1728.
[69] Holden, Peregrine, 'Family History and Hospital History in the Middle Ages', unpublished paper, 1999. I wish to thank the author for allowing me access to this work.

(frequently lengthy) existence. Similarly, with the possible exception of cases involving inheritance in return for the maintenance of one's elderly relatives, we do not find the prevalence of the establishment of 'social capital' as expounded by Pierre Bourdieu and by Martin Dinges in his study of Bordeaux.[70] For the most part, the patterns of care referred to within the petitions related to bonds of familial loyalty and duty. Moreover, many of the family patterns evinced here do not fit into the neat categories, so fêted by demographic and quantitative historians. Neither is there a clear-cut point in time in which a chronic condition becomes an untenable situation. The precise timing relates to individual circumstances, although obviously, many of the stages follow a certain pattern.

For the rural poor of early modern Hesse, 'family' and 'kin' networks were understood in much wider and subtler terms than previous historical studies have suggested. To some degree it would appear that the parental obligation was the strongest of those evinced in the petitions. This point should perhaps not be overstated however. As the examples here have shown, chronic illness combined with poverty could mean that even the strongest family bonds reached a breaking point. The petitions mentioned here reveal the existence of complex households, involving players such as orphans, grandparents, stepchildren and guardians. While these cases may suggest that the obligation of care was weaker in this kind of complex family, this does not appear to have been the case. Admittedly, sudden changes to the household structure might mean that this 'new' family unit was unable to cope any longer with the burden of providing for a family member who could not contribute to the household economy, other than as a drain of resources. A good example of this relates to life-cycle events such as the death of a spouse - especially if he or she also left behind a large family of small children. At this point an application was often made for the invalid to be received into one of the hospitals. As Mary Fissell also discovered in her study of the eighteenth-century Bristol Infirmary, illness alone did not turn an individual into a hospital patient. Contributory factors which served to tip the balance between coping and not coping included family breakdown, loss of employment, old age,

[70] Bourdieu, Pierre, 'Structures and Habitus', in Idem, Outline of a theory of practice, Cambridge, 1977, pp. 78 - 95; Dinges, 'Self-Help'.

and the presence of a new mouth to feed.[71] Nevertheless it must be noted that in Hesse, cases do exist which involve 'weak' households (such as one-parent families), in which the invalid had been maintained for a not inconsiderable time before the application was made.

A large proportion of cases involved legitimate parents taking their offspring to the hospital. Most frequently, the children had laboured under their illness since early childhood. Generally speaking, these cases can be separated into two groups. In the first group, applications were made when the children were at an age when they should be contributing to the household income, but their physical state rendered this impossible. Economic concerns - especially if the child was one of a large family, including many small children - were thus a decisive factor. It is frequently clear that the application had been put off until the last possible minute. As the case of pastor Bergius reveals, such stalling had much to do with affection and emotion - issues which historians have all too frequently ignored. Bergius hoped that his son would recover, and was willing to undergo all of the hardships that this wait involved to keep his child within his family unit. While such emotional attachment is most evident in cases involving legitimate parents, it is not always wholly missing from instances concerning more complex households.

The second group consisted of parents who felt that they were now too old or infirm to continue to care for their charge. Any other offspring had inherited their parents' poverty, and were unable to help out. It might also have been that the parents, to an extent, did not wish their offspring to offer assistance. They wanted the best for all of their children, and were all too aware of the burden of caring for their invalid child, especially within an impoverished household.

We must be wary of making sweeping generalisations regarding the nature of familial and communal care in the early modern period, and must keep in mind the narrow focus of the source base. It may well be that the sick poor of the Hessian petitions had a different 'experience' of chronic illness to that evinced in

[71] Fissell, 'Sick', p. 38.

other historical studies. Beier has suggested that chronic illness prompted different expectations in terms of 'sickness behaviour'. Thus, in the case of Ralph Josselin, although he 'was able to preach during the last ten years of his life, he behaved in other respects like a sick person, trying many remedies, consulting several healers, and expecting special services and consideration from family members'.[72] Usually, states Beier, if one was generally (as opposed to chronically) sick, those 'people well enough to be out of bed were entitled to complain about discomfort, but were expected to carry on with their normal duties'.[73] The difference in documentation type (i.e. a diary versus petitions) may account for some of the change in perspective. I would suggest however that the chronically ill poor had a rather different experience of 'being ill'. Dependent upon their earning power for their survival, they were unable to afford the luxury of any 'special services'. Instead they were forced to alter their occupation to fit in with their decreasing physical capabilities. In the case of 'children', applications often stemmed from the fact that they would never reach the point of maturation when they would be able to be a productive member of the household, and the family unit was no longer able to support this constant drain on resources. In these cases (and in comparison to Beier's findings) their chronically ill status afforded them no extra privileges within a family that was barely keeping its head above subsistence level. The meaning of family and familial care as evinced in the Hessian petitions constituted a much wider range of factors and considerations than historical research has hitherto attributed to it. By looking at evidence concerning the experiences of both the invalids themselves and their carers, we can come closer to understanding the notion of the locus of care.

[72] Beier, Lucinda McCray, 'In sickness and health: A seventeenth century family's experience', in Porter (ed.), Practitioners, p. 125.
[73] Ibid, p. 125.

CHAPTER SIX
LABOURING UNDER A PHYSICAL ILLNESS: THE ROLE OF WORK IN THE LIVES OF THE CHRONICALLY SICK.

In the previous two chapters we have considered the way in which a person's age and the network of care available to them effected their experience of chronic illness and precipitated their application to enter the *Landesspitäler*. A constant theme that is clearly interwoven throughout these chapters relates to a person's capacity to work. As has been alluded to in the first chapter, it is clear that, from the outset, the Landgrave made a clear connection between unsustainable poverty and an inability to work or otherwise provide for oneself. This was one of the necessary prerequisites for application. It proved to be a continuing concern throughout the period under consideration here

The interconnection of a comprehension of illness being directly linked to an inability to work was widespread in the early modern period.[1] Chronic illness clearly affected the career choices of all classes. Lucinda McCray Beier's study of the diaries of Ralph Josselin comments upon the pain, 'swelling and ulceration' in Josselin's 'left leg, which was variously diagnosed as scurvy and dropsy', and was the bane of the last decade of his life. Josselin suffered from this condition from at least 1673, and, according to Beier, it 'incapacitated and probably eventually killed him'. (He died in August 1683.) Beier reports: 'By early 1683, after ten years of misery, Josselin was a very ill man indeed. His leg was swollen and painful. His belly also swelled. He was very short of breath. He developed a 'great and dangerous cough' and double vision. Despite his infirmities he continued to preach'.[2] Suffering from a chronic condition was thus not necessarily synonymous with an inability to work – although in Josselin's case it is unclear whether this continuity is linked to his piety. As discussed in Chapter

[1] See among others, the comments of Robert Jütte in Idem, 'The Social Construction of Illness in the Early Modern Period', in Lachmund, Jens & Stollberg, Gunnar (eds.), The Social Construction of Illness. Illness and Medical Knowledge in Past and Present, Institut für Geschichte der Medizin der Robert Bosch Stiftung, Medizin, Gesellschaft und Geschichte, Band 1, pp. 23 – 38, here p. 27.
[2] Beier, 'Sickness', in Porter, Patients, p. 113.

Two, however, chronic illness could also force an individual to change their profession to fit into their current physical (or mental) capabilities.[3]

What did it mean to suffer from a chronic physical condition for 'those [persons] whose daily labour is necessary for their daily support ... whose daily subsistence absolutely depends on the daily unremitting exertion of manual labour'?[4] Studies to date that have looked at issues of work within hospitals (or indeed within poor relief) have largely considered it as an expression of the imposition of elite authority over the masses. They primarily concern issues such as the idleness of the poor and the foundation of workhouses. This focus gives an overwhelmingly negative view of the poor from an elite or middling perspective. Comparatively, work on poor relief has revealed ways in which the poor were able to obtain relief in return for working for the parish in some form. Perhaps the best known of such studies are those which concern England, notably Margaret Pelling's work on Norwich, and Andrew Wear's article on the parish of St Bartholomew, London. [5] While this viewpoint is not so negative, it still finds its basis in forms of work which are effectively imposed upon the poor by authorities – a failure to accept any of these job offers would result in a reduction of poor relief for the individuals concerned. It is true that in a large number of the petitions upon which this study focuses, the invalid applied to enter either Haina or Merxhausen because their physical state did not allow them to work or provide for themselves any longer. It is a central argument of this thesis, however, that a more nuanced understanding of the relationship between the connection between work, illness and incapacity is required. How would the capacity of a sick person to work and support themselves impact upon their self-perception? How did this self-image affect the sick individual's view of the role that the *Landesspitäler* would play in their lives?

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[3] For parallel examples from a middle-class perspective, see Jütte, 'Weib', especially pp. 11, 13. Jütte recounts that Hermann Weinsberg, a councillor (*Ratsherr*) from Cologne, was plagued by the 'pains of a hernia' (*Bruchleiden*) throughout his life. In his chronicle, Weinsberg blames this chronic condition for affecting his career opportunities. His account suggests that this rupture (*Leistenbruch*) prevented him from entering a diplomatic career at a princely court following his law studies. The hernia stopped him from undertaking long and tiring journeys, and thus rendered such a career option untenable.

[4] Quote taken from Eden, Frederick Morton, The State of the Poor: Or an History of the Labouring Classes in England, 3 volumes, 1797, here Vol. 1, 4.

[5] Pelling, 'Norwich'; Wear, 'Bartholomew's'.

There are numerous themes within the petitions that relate to the subject of work. The constraints of the thesis limit the focus to a consideration of only some of these aspects. Topics that cannot be detailed fully here include issues of work, honour and the associated and implied 'right' to hospital care. The latter relates especially to those people who had previously been hospital employees (in the broadest sense) and also those who had fought for the state, namely soldiers. This corresponds to the concept of reciprocal care as owed due to services rendered (the right to assistance), and notions of responsibility (the Landgrave as patriarch). An associated idea is the way in which this 'honour' was assumed by the petitioners to be transmuted to relatives. Some of these themes have already been alluded to in the cases cited in the previous two chapters. An additional facet of the 'work' question concerns accidents – both in the workplace and within daily life. Accidents as a cause of an inability to work are another common theme within the petitions.[6]

This chapter will focus upon two aspects of capacity and incapacity to labour as experienced by the hospital inmates. The first instance will concern the pre-petition situation, namely an individual's ability to cope with an illness (frequently for a not inconsiderable time) prior to requesting hospitalisation. The gradual nature of the process by which the onset of a chronic illness or condition signalled the immediate need for institutionalisation has already been illustrated. An invalid would adapt his or her lifestyle (most notably their occupation) in order to accommodate their affliction. An application only arose as a last resort, when all other options had failed. A key theme that will emerge from this chapter is the self-perception of capability among the sick - 'coping'. The central role that the ability to work plays in a person's identity will also be addressed. We will consider the effect that the capacity to work had upon the experience of an invalid, both from the vantage point of the sick invalid themselves and also of their family. In this sense, the importance of the individual within the household economy will be brought into question.

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[6] For detail regarding these topics, see among others, Gray, Louise, 'Work, obligation and illness. Pauper narratives and territorial hospitals in early modern Germany'. Paper presented at the Wellcome Unit for the History of Medicine at University of East Anglia, November 2000; Idem, 'Survival and incapacity: work, illness and self-perception among the labouring poor in early

The second section of the chapter will briefly detail notions of work, capability and self-identity within the hospital itself. It will be argued that such issues should not solely be regarded as an indication (in a Foucaultian sense) of the state imposition of its authority over the poor. As will be shown, a person's ability (and willingness) to be productive also influenced their social identity within the hospital.

I. Illness and a capacity to work.

A common theme in the petitions is the way in which a chronic illness can change a person's life course, as it renders them unable to practise their profession. In some cases this corresponds directly to training in a specific trade. Documentation from 1713, relating to Conrad Grone from Deissell in the district of Treu Felburg [sic], detailed that he had been apprenticed as a smith. In the course of his training however he had been stuck down by a stroke (*schlagfluß*) which had rendered the left side of his body lame. His left arm was particularly affected and it shook continuously. Consequently he was unable to continue in this profession, and was forced to collect alms.[7] A petition from thirty-six year old Johann Jacob Braun, a 'journeyman clothmaker' [*Tuchmachergeselle*] offers a similar picture. Braun suffered from fluxes (*Saltzflüssen*). An attack of 'gouty [or arthritic] fluxes' [*Gichterischen flüßen*] had (in spite of his vain search for medical cures) left him a cripple. He had however managed to support himself for two decades as a cloth-worker (*ein Wollenknappe*), working for a variety of masters. He was no longer able to sustain this type of employment and thus had no means of providing for himself. [8]

As has been illustrated throughout many of the cases cited here, many of the applicants were labourers. As such, their employment remit was meant to be much wider than that of those persons who were trained in one specific profession. We do not however find here the situation that Geoff Hudson has

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modern Germany'. Paper given at the conference 'Beyond the Gaze: Gender and Self-Perception', University of Essex, June, 2000. I plan to expand upon these topics in due course.

[7] LWV, Bestand 13, Reskripte, 1713.

unearthed in England, whereby greater emphasis was given to 'the inability to continue a trade' rather than 'the inability to labour'. Hudson explains this in the following manner: 'This was the case because the men with a trade could more easily link a specific physical problem to an inability to do a specific trade than an inability to do any form of labour...'.[9] In contrast, many of the Hessian petitioners offer similar explanations for both skilled and unskilled professions. The latter case is illustrated most clearly in instances of herdsmen, whereby they relate their inability to continue this employment with a weakened capacity for mobility. Whether those who had learnt a trade were less likely to adopt a variety of occupations as their physical capacity allowed them, or indeed whether these persons were more likely to enter a different type of hospital (an urban institution, for instance) are considerations which are outside the immediate scope of this thesis.

II. Incapacity and the household economy.

The necessity to work in order to survive also affected the ability of a carer to provide adequate assistance for their charge. As briefly mentioned in Chapter Three, poverty could compromise an individual or family's ability to provide the invalid with the necessary level of care. This theme is particularly relevant amongst cases in which parents were caring for an incapacitated child – and often had already done so for many years. Themselves poor, and reliant upon their daily work for the survival of the household, they were left in an untenable situation. They needed to work in order to provide for their families, but they also needed to be at home to care for the sick member of their family. In this instance, as has been shown, the petition was normally formulated as a result of a death of a spouse, the seniority of the parents, or the worsening of the invalid's condition to the extent that they required constant attention. The latter case occurred most frequently within the surviving documentation when the invalid was suffering from epilepsy or from some form of mental illness. The patient was depicted as either being a danger to themselves, or as putting the whole

[8] Ibid, 1712.
[9] Hudson, Ex-Servicemen, p. 349.

community at risk. Fire, water and (predominantly in cases of mental illness) the potential for violence were the main causes of concern.

One of the earliest examples of this process can be found in the 1596 case concerning the son of Hardtmann Nebe from the village of Schiffelbach.[10] According to the report of the Jost Wetter, the mayor of Gemünden an der Wohra, Nebe's son suffered from the 'heavy burden of the falling sickness', an affliction which was believed to have been sent by God. The boy was approximately twelve years of age, and he suffered from epilepsy to such an extent that he had 'two or three attacks' a day. This 'weakness' had affected him both physically and mentally. It had damaged 'not only his senses and [his] reason', but it had also attacked his limbs, so that he 'cannot move or stand properly', causing his movements to be as those of a young child. Hardtmann Nebe and his wife lived with their children in 'great poverty'. As 'pious industrious people, who owned nothing other than what they could earn through their manual labour', they were forced to go out to work in order to ensure the family's survival. Their invalid son was however a constant source of worry to them. Forced to leave him at home while they went out to work, they were afraid that their son might thereby be endangered. They feared that he might 'fall into water or into [a] fire', and that, 'as a result of this lack of care (*Wartung*)', he might finally be killed by these potential hazards.[11] The parents thus felt that they had no other choice than to request that their son be taken into Haina, where they believed that he would receive the care that their social circumstances prevented them from providing.[12]

III. Survival and the importance of a marriage partnership

Examples also exist which stress the significance of a husband and wife partnership in both an economic and caritative framework - among the poor at

[10] Also spelt 'Harttman'.
[11] Regarding childhood accidents, see Gordon, Eleonora C., 'Accidents among Medieval Children as seen from the Miracles of Six English Saints and Martyrs', Medical History, 1991, 35, pp. 145 – 163.
[12] LWV, Bestand 13, Reskripte, 1596.

least. Such evidence is contrary to the notion of the male patriarch and the suppressed female in this period, and fits in with the work of Heide Wunder that stresses the role of the marriage partnership in this period.[13]

The 1699 petition of George Diepell illustrates some of these points. At the time of his application, his wife was over 70 years of age. She was deaf and suffered from a variety of other infirmities. She was wholly unable to earn her bread, and was even unable to beg. Her husband however was similarly old, and his own frailties meant that he was unable to support her any longer. He thus applied for her to be taken into the hospital. We learn from the pastor's report that a few years previously a fire had destroyed the family home. In his attempt to re-build somewhere to shelter his wife and children (the latter were presumably similarly poor and unable to provide assistance), the family had accumulated many debts. Reduced to begging, and with the frailty of old age, the family unit had slowly broken down. Moreover his own infirmities now meant that he was unable to support both himself and his wife through his begging.[14]

The gender imbalance should not be assumed however. Insufficient documentation frequently renders studies of widowers impossible.[15] Hessian petitions from widowers exist however that highlight the importance of the marriage partnership in coping with illness. The central role of the wife in the household formation, especially in old age is indicated by the 1688 application of Caspar Riell, a former attendant of the poor ('Armen Wartter') in Haina. His petition reveals that he was appointed to his position in Haina in 1679, which service he had faithfully undertaken. In the mean time, however, his wife had died, and due to his age, this 'poor old man' was 'no longer able to earn his daily

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[13] See especially, Wunder, Sun, pp. 63 – 84; Idem, '"Jede Arbeit ist ihres Lohnes wert"', in von Hoffmann, Barbara et al (hrsg.), Heide Wunder: Der Andere Blick auf die Frühe Neuzeit. Forschungen, 1974 – 1995, Königstein / Taunus, 1999, pp. 170 – 186.

[14] LWV, Bestand 13, Reskripte, 1688.

[15] Regarding the problems of locating widowers within sources, see Pelling, Margaret, 'Finding widowers: men without women in English towns before 1700', in Cavallo, Sandra & Warner, Lyndan (eds.), Widowhood in Medieval and Early Modern Europe, London, 1999, pp. 37 - 54; Crick, Julia, 'Men, women and widows: Widowhood in pre-Conquest England', in Cavallo & Warner (eds.), Widowhood, pp. 24 – 37, here p. 30. Of his study of poor relief records in fourteenth-century Florence, John Henderson commented that 'men were never identified as widowers'. (Henderson, John, 'Women, children and poverty in Florence at the time of the Black

bread. It may be, therefore, that similarities of experience existed for the elderly poor and infirm across the gender divide, whereby their increasing infirmity, coupled with their isolation (in the case of those who had recently been widowed) would have weakened their resolve for self-help.[16]

Such issues are evident in the 1728 case of Johannes Quell of Weymar in the district of Kassel. Reports from local officials, the parish pastor, and Johannes revealed that he was lame and was forced to get around with the use of crutches. His condition had arisen as a result of an accident - whilst in a forest, a tree 'fell on ... [his] leg'. (Unfortunately the details are very hazy here.) Following the death of his wife, he had no one else to care for him and had no way of earning his upkeep.[17] The image of a partnership between the spouses is once more reinforced here.

Perhaps the clearest indication of the potentially enormous impact that a marriage partnership could have upon a person's ability to cope with a chronic illness can be found in the 1717 documentation relating to Emanuel Gross. We learn that Emanuel had been very frail since childhood. His infirmities had gradually lead to his being forced to give up a variety of occupations. Initially he had provided for himself through his work as a swineherd at a farm in Wolkersdorf. His increasingly deteriorating physical condition meant however that he was soon unable to carry out this work. He also worked as a cowherd. Unable to undertake any form of physical work [*schwere Arbeit*], he regarded entrance into Haina as his last hope. Although he was granted a place in Haina, on 3rd of December 1717, Emanuel Groß married. The petition suggests that this new social status led to his forfeiting his place in the institution. The document merely states 'married and not received'. Whether the fact that he now had a wife to care for him rendered void his application to Haina, or whether it was a personal decision is unclear. It seems, however, is that his wife, Gertrud, was more than capable of looking after him. After this date he does not appear to have petitioned for reception into Haina. Emanuel and his wife remained

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Death', in Henderson, John & Wall, Richard (eds.), Poor Women and Children in the Past, London, 1994, pp. 160 – 179, here p. 166.)

[16] This is an issue that I plan to expand upon at a later date.

childless, and, in spite of the infirmity of the former, they farmed approximately two hectares of land, and also worked as day laborers. Emanuel died in approximately 1736, and his wife in 1741, at the age of 66. The fact that, despite his infirmity, he and his wife were able to provide for themselves in this way does not necessarily diminish the level of his infirmity. It is likely that had he gained entry into Haina, he would have been one of the *Hospitaliten* who were able to undertake a certain amount of daily work. Without some form of household partnership and the back up care that the marriage allowed him, however, his level of infirmity seems to have prevented him from coping alone.[18]

Work clearly played a crucial role in the pre-petition lives of the chronically sick, both for the invalids themselves and also for those who cared for them. As will be shown, the importance of an individual's capacity to labour did not end at the hospital gates.

IV. Work and capabilities within an institutional framework.

One of the most crucial insights to emerge from the petitions is the central importance that an individual's capacity to work played in shaping their identity, and the overwhelming desire of many of the applicants to continue working, if at all possible.[19] (As has been alluded to already, this does not seem to have been the case for some of the much younger applicants who had suffered from birth and had never been able to work. Overwhelmingly, in these instances, the key factor is the ability of their carers to continue working – as has been illustrated in both the case of Hardtmann Nebe and also in the previous two chapters.) The key issue at work in the applications was that an individual was no longer sufficiently able to support him- or herself. This state of affairs was mirrored in the hospital ordinances. Any inmate who sufficiently recovered their health to be able to earn their living independently was to leave the hospital – such 'success stories' did

[17] LWV, Bestand 13, Reskripte, 1728.
[18] Case cited in Stöhr, 'Armer', pp. 92 – 93.
[19] Compare to Sokoll, Thomas, 'Selbstverständliche Armut. Armenbriefe in England 1750 – 1834', in Schulze, Winfried (hrsg.), Ego-Dokumente. Annäherung an den Menschen in der Geschichte, Berlin, 1996, pp. 227 - 274, here p. 259.

exist, although they are relatively few in number. This should not surprise us, when we consider that an applicant had to be suffering from a seemingly incurable condition to be deemed eligible for consideration in the first place.

Perhaps the most important lesson of which these petitions remind us is that we should not automatically equate chronic physical illness with a total inability to perform any form of work. In spite of their physical afflictions, some of the petitions reveal a specific desire on behalf of the patients to continue working within the confines of the hospital. In the 1576 correspondence relating to Georg from Scholley, he explained that (as his community could testify), he was 'still able to assist others with wood chopping (*hawen*) and other menial tasks.'[20] The crucial point however is that he was unable to earn enough through the small amount of work that he could perform to support himself.

Other cases exist in which an individual requests to become a hospital employee rather than a patient – thus their families would be able to accompany them to the hospital. Evidence of this can be found in the 1712 case of Hubert Vitterer, a former injured (*blesirter*) soldier born in Schmalkalden. Vitterer explained that he and his wife were now so frail that they were unable to work, but 'they [still] wished to earn their bread'. He thus requested that he be considered for the next vacancy as a porter at Haina. The monetary pay for this position was 'meagre' – the job's attraction was that the individual (and his immediate family) would receive shelter and protection from the hospital network, including food and clothing. The crucial point to note in this petition (and others like it), is that Vitterer offered similar arguments in requesting this post that the other (inmate) petitioners used – namely that his physical condition was sufficiently weakened to mean that he was unable to support himself (and his wife) through his earnings alone. Acceptance into the hospital would ensure the care of Vitterer and his wife and would mean that he was able to work in some form within the wider care network of the hospital.[21]

[20] LWV, Bestand 13, Reskripte, 1576.

The belief in the potential ability of the working invalids was not restricted to adults. The parents of sick children did not rule out the possibility that their offspring could learn a trade. This is amply illustrated in the 1717 request of Anna Elisabetha Simonin, a 'poor inmate (*Mit Hospitaliten*)' in Merxhausen. She had resided in the hospital for the past thirteen years. Approximately seven years previously, she had been allowed to have her 'two small children, namely two twins... one son and one daughter' join her in the hospital. She had cared for them in Merxhausen, and they had been allowed to remain in the institution until they were confirmed. Her daughter had been confirmed the previous year and had duly left the establishment. Her son's confirmation was to occur later in the year (at Whitsun). She requested that her son be allowed to remain within the territorial hospitals' care (moving to Haina) so that he could be trained to be a tailor – this would take two years. Further reports indicated that due to the boy's 'weak nature', he would be unable to perform any 'heavy or hard work' (*schwerer arbeit*). Unable to support himself in the outside world, the boy was taken into Haina and contributed to their economy through his apprenticeship – a position that he would have been unlikely to obtain in the outside world.[22]

Instances exist that reveal how individuals, believing themselves to still be sufficiently able to earn their living, requested to leave the hospital. Thus in 1707, Joh. [sic] Jacob Krämer and Joes Biedenkapp wrote to the visitation commission and the superintendent of the hospitals. They detailed how they had entered the hospital five years previously, suffering from 'open ... leg wounds'. It would appear that they had trained as tailors during their stay in the hospital. Their injuries were now much recovered, and they therefore requested that they be allowed to leave the hospital and to try and support themselves. They asked to be granted some form of clothing and some money to facilitate their attempts at independence.[23] Interestingly the applicants stressed that, in the event of their medical condition worsening, they wished to be allowed to return to Haina

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[21] Ibid, Reskripte, 1712. Similar requests (usually from former military men) can also be found in earlier periods. See for instance, the petition of Sittich Niberneber from Milsungen. (LWV, Bestand 13, Reskripte, 1611.)

[22] LWV, Bestand 17, Reskripte, 1717. Compare to Ogilvie, Sheilagh C., 'Coming of age in a corporate society: Capitalism, Pietism and family authority in rural Württemberg, 1590 – 1740', Continuity and Change, 1, 3, 1986, pp. 279 – 331, here p. 292.

[23] LWV, Bestand 13, Reskripte, 1707.

immediately. Such cases offer important insights into an individual's perception both of their own capabilities and also of the role of these institutions in their lives. Both Krämer and Biedenkapp specifically stated that their situation had improved sufficiently for them to believe that they would be able to maintain themselves outside the hospital. Crucially, however, they did not state that their afflictions were 'cured'. Whether this was a strategical device to add weight to their request that they be allowed to return immediately should their condition worsen – thus being in a sense a 'life-cycle strategy' – can only be guessed at. Alternatively, it may well be that experience had taught these men that their ailments were likely to return. Given the option, they would rather have left the hospital, but they were aware that, should their medical state revert to that of their pre-petition phase, they would require the support of the hospital once more. It is important to note that they had utilised their time as patients to learn a trade. They presumably now believed that they were more able to cope with life outside the institution than before. While this type of record is particularly scanty, more in-depth research needs to be done into this category of petition in order to offer us a broader understanding of the chronically sick person's notions of hospitalisation and the ability to cope.

V. Work, identity and the self-perception of the hospital patient.

If capable, a hospital inmate was expected to perform daily light work within the institution. This was not a profit-making exercise, but was instead intended (according to the foundation ordinance) to prevent idleness and temptation by the Devil. The work was to be of a light nature and was supposed to fit in within the individual inmate's capabilities.

Documentation from 1717 and 1719 relating to one of the hospital brethren, Johan Diedrich Simmersbach is indicative of the tensions that could occur when an individual's perception of his role as a hospital patient differed from that of the institution and indeed also from the ideas of fellow patients. Simmersbach complained to the hospital visitation committee that his food allowance had been cut and that he had been imprisoned for his inability to work. He stressed that his

action was due to a physical weakness and incapability rather than a shirking of responsibilities. He also mentioned that he had requested clothing but had received neither of these items to date.

Correspondence from the hospital superintendent (Wilhelm von Urff) confirmed the situation, but stated that the punishments were implemented because the patient (*Hospithalit*) refused to go to work like other individuals. These restrictions were to be kept in place until he [conformed and] worked.

The outcome of this case remains unknown. Nevertheless the accompanying inquest offers some interesting insights regarding a person's identity and their capacity to labour. When questioned, the fifty-two year old Simmersbach described himself as 'old and weak'. He stated that the injuries that he had received through his many years of military service had left him incapable of any form of strenuous work (*starcker arbeit*).

A report from hospital officials detailed the types of work that capable patients were expected to undertake. Winter activities included chopping the required wood for the kitchen and for their accommodation. Summer work included haymaking and fruit picking. For this work, inmates would receive certain perks such as extra bread and cheese. The authorities believed Simmersbach to be capable of such menial tasks. Indeed, he was believed to be one of the 'healthiest' (in comparative terms) patients within Haina at the time. It was specifically stated that his age did not exempt him from these duties.

When further questioned, Simmersbach stated that his military wounds rendered him incapable of undertaking the forms of work that other impotent inmates were capable of. Due to the nature of his injuries - he had been stabbed - he became short of breath when he worked. Contrary to Simmersbach's assertions however, was the claim that he had told a hospital attendant that 'he could work as well as the best [inmates] but he did not wish to do this'. Moreover he stated that the Landgraves had ordained that he be exempt from all work. When asked about this incident, Simmersbach merely answered that 'the attendant sometimes spoke many untruths'.

The attendant (Peter Schneider) was duly interrogated and swore that Simmersbach had in fact made such a statement, not only in front of himself, but also 'his wife [and] also other competent (*verständigen*) brothers'. This employee was further asked if, during the time that Simmersbach had been under his care, he (the patient) had been confined to bed and had been weak (*bett lägerig und schwach*). He answered that 'he had not seen or heard anything to even slightly' suggest this condition. In fact quite the opposite was true. One of the barber surgeons ('quite which one ... [he could] not remember'), had reported to the attendant that 'he had seen no brother who was healthier or livelier (*frisch*) than' Simmersbach. When questioned, the attendant also stated that Simmersbach had appeared to be drunk (*berauschet*) on several occasions, and had also hit his wife on one occasion. (It is unclear whether this refers to the attendant's wife, or to Simmersbach own wife.) Simmersbach had been punished by the hospital governor for the latter offence.

Johann Friederich Halbach, the hospital surgeon, was also questioned. His report claimed that he had been requested to visit Simmersbach and had found a 'severe (*schlechter*) flesh (*haupt*) wound on his right side. Secondly, approximately twelve years previously he had been stabbed whilst in military service. The wound in his chest was two fingers wide and the weapon had gone straight through his body, under his ribs and out through his back. Halbach concluded however that this wound had been cured, meaning that Simmersbach was able to undertake the 'minimal work' in the hospital as required of other inmates who were of a similar physical condition to the plaintiff.[24]

This thesis does not deny that the authorities imposed their power in forcing those inmates that they felt capable of work to work – punishments included having their food taken away and imprisonment. The Simmersbach case (and others like it) suggests however that there was also another force at work here that was linked to the notion of identity and a division between the stages of chronicity experienced by hospital inmates. It would seem that the inmates – just as the authorities – distinguished between those of the brethren who worked and

[24] StAM, Bestand 17II, Nr. 2700.

those who did not. In spite of the physical afflictions of all of the hospital population, the inmates considered those who were unable to perform any duties to be 'ill' in a different manner to those who were able. It was as if the former group were deemed to be more ill or at a more advanced stage of their illness than the latter. The reality of this may be wholly different, for some patients were described as bedridden and yet spent many years in this state within the hospital. The latter stage was however deemed by many to be the one of the only times during which one was 'honourably' able to claim to be incapable of working. The inability to perform the socially useful action of 'work' gave this group of patients a distinct identity within the eyes of other inmates. (Obviously the 'dangerous mad' were also unable to work. It is unclear whether a similar notion of honourable discharge was also attributed to them.)

As the Simmersbach case reveals, an individual's notion of their capabilities did not always tie in with the views of the authorities – nor indeed with the rest of the patient population. In many respects the key point to emerge from the interrogation process was that Simmersbach did not behave like a person who was unable to work – he had not proved himself to be bedridden and suitably weak. Such issues are echoed in other documents in which patients complained about the actions of their fellow inmates. In both 1683 and 1742 a group of sisters in Merxhausen petitioned about the behaviour of their fellow female patients. One cause of complaint related to labour. These women were (in comparison to the plaintiffs) relatively young, yet they deemed themselves incapable of work. The correspondence from 1742 stated that the types of 'light work' that the sisters were asked to perform were considered to be of a nature that 'even the smallest child' would be able to perform them – this included involvement in cloth manufacture, assistance in the kitchens and bakery, work in the garden and the carrying of fruit. Their inability to perform these tasks was deemed by the authorities and the other inmates to be a charade and a further sign of their insubordination. The other patients, however, seemed to regard it as a sign that the younger, marginally more mobile patients were not behaving in a

manner that suited their position (and by implication their medical condition) at this point in time. [25]

This chapter has briefly considered aspects of capability and incapacity among the patient population. The crucial role of work in the pre-petition phase of a sick person's life has been illustrated. The importance of this issue frequently carried on into the hospital life of the afflicted however – unless they were so incapacitated as to render all work (and usually all movement) impossible. We should therefore be wary of equating the sufferance of a serious medical condition with the automatic inability of a person to perform any sorts of task. Irrespective of the provision of the hospital that those who could work should do so, it would appear that many persons considered it important that they be allowed to continue to work once within the hospital. An ability to continue working in some capacity was central to an individual's sense of identity and self-worth. The patients themselves seem to have made distinctions in these matters and classified those persons within the hospital who failed to work as 'unworthy' of a place therein. They questioned their infirmity and suggested that they were in fact healthy and workshy, using much the same language that the authorities used against the unworthy beggars and vagabonds. Far from merely equating illness and poverty with a request for hospitalisation, the petitions of the Hessian poor suggest that the whole process of the self-experience of chronic illnesses is one that needs a more subtle and in-depth analysis than it has hitherto been afforded.

[25] StAM, Bestand 17I, Nr. 870.

CONCLUSION.

This thesis has offered a wider picture of the *Landesspitäler* than is usually given in hospital histories. A dearth of surviving sources and the specific research interests of individual authors have meant that most studies to date have depicted early modern medical institutions either through their administrative and bureaucratic records or through their patronage and funding measures. As I have illustrated in Chapters Two and Three, an over-reliance in previous studies upon documentation such as foundation ordinances and patient lists has masked the reality of the situation. The dangers of relying solely upon the latter as a representation of the ailments suffered by the inmates was clearly exemplified by a comparison of the brief information available from these documents to the diversity and multiplicity of illnesses registered in the admission petitions. Similarly, as highlighted in Chapter Three, the silence afforded to medical care within the hospital ordinances should not be taken as proof that no such facilities were offered to the sick inmates and that the institutions in question were little more than 'Protestant monaster[ies]'.[1]

This study has also considered the territorial hospitals within their wider regional context. One of the contentions of this thesis is the necessity of acknowledging the influence that external events had in shaping an institution. I have placed a particular emphasis upon the impact of both natural disasters and war (most notably the Thirty Years War) on the running of these institutions. Such effects found their expression both within the devastation that was caused to the *Landesspitäler* and the state of Hesse in a purely material sense, and also in the impact that these catastrophes had upon communal and familial networks. For example, many petitions made specific reference to the Thirty Years War as the primary cause for their inability to continue to be self-sufficient. The reasons for the latter related to both material considerations – including pillaging by troops and the destruction of buildings and crops during the fighting – and the effects of the War in human terms. Chapter Five cited examples in which the extended

[1] See Midelfort's remarks regarding Haina. (Midelfort, 'Protestant'.)

family had been called upon to offer care and support following the death of spouses and parents during the fighting. The impact of this loss of life had far-reaching consequences. This was an increasingly important consideration throughout the period of study as Hesse embarked upon a policy of leasing out its troops to fight in other military forces.[2] As a result, many petitions - from the elderly especially – recounted that their sons had been killed in military service, thus denying the applicant any assistance that their offspring might have offered them. In addition, requests for admission arose, with increasing frequency, from injured soldiers, seeking aid and shelter as recompense for their many years of service to the state. In all such instances, a sense of entitlement emerges from the petitioner. This stemmed from the recognition afforded to the sacrifice made by either the individual soldier to the state in terms of his own physical or mental health, or by the close relative (usually a parent or sibling) in sacrificing the life of their loved one for the greater good of the state. These are issues that have been alluded to in this study and they require further research.

How are we to relate the findings detailed in this thesis to the discipline of hospital history? This question will be considered through the dual topics of the institutions and the patients.

I. Hospital History and the *Landesspitäler*.

Historians of hospital history have frequently displayed a keenness to categorise their study hospital within a hierarchical framework. Can the institutions in question be regarded as 'hospitals' in a medical sense, or did they offer a continuation of a medieval caritative service? While such classifications are undoubtedly useful, it sometimes leads to the dismissal of these establishments as non-medical and akin to our modern-day hospices. Such arguments have usually been accompanied by discussions of the eighteenth-century 'medicalisation' process and the rise of both clinical medicine and the modern hospital. Studies such as that of Francisca Loetz have, however, brought such

[2] Ingrao, Charles W., The Hessian Mercenary State. Ideas, Institutions, and Reform Under Frederick II 1760 – 1785, Cambridge, 1987.

linear accounts of progression into question. Loetz's work on late eighteenth- and nineteenth-century Baden has queried the thoroughness of the 'medicalisation' procedures.[3] In contrast, Robert Jütte and Annemarie Kinzelbach have suggested that this process was already relatively established, in towns at least, in the sixteenth and seventeenth centuries.[4]

Bearing in mind the problems inherent in trying to fit the *Landesspitäler* into a historiographical framework of linear progression, where are we to locate these institutions within the framework of medical historiography? Are we to dismiss them, as Midelfort has done for Haina, as displaying the 'the admission requirements for a nursing home, rather than what we might today expect of a hospital'?[5] Or should we stress, as Robert Jütte has done, their 'unique [nature] at the time of their foundation'?[6] What references should we use to describe them? Were they 'Protestant monaster[ies]' or 'charitable institutions'?[7] Terminology was clearly an individual affair to contemporaries, for the institutions were variously referred as *[Ho]spitäler*, monasteries, hospitals of the poor, and, rarely, as poorhouses. Frequently, these categories were interchanged within an individual petition, reminding us once again of the fluidity of linguistic expressions in this period. After all, as has been illustrated, the hospitals quickly admitted persons other than the destitute poor.

This thesis has discussed the *Landesspitäler* with regards to the role played by religion, politics and welfare policies in the early modern period. The interplay of some of these issues received perhaps its clearest iconographic expression in the *Philippsstein* (Figure 4). These factors are topics that can be expanded upon at a later date. The role of Haina and Merxhausen as medical institutions is our primary focus. The territorial hospitals clearly cannot be equated with 'modern' medical establishments. Neither could we expect them to be. While further comparative research is required to ascertain whether – as I suspect – other, similar, institutions existed within this period, the conception of the

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[3] Loetz, Kranke.
[4] Kinzelbach, Gesundbleiben; Jütte, Robert, Ärtze, Heiler und Patienten. Medizinischer Alltag in der frühen Neuzeit, München, 1991.
[5] Midelfort, Madness, pp. 330 - 331.
[6] Jütte, Poverty, p. 213.

Landesspitäler depicts a somewhat different type of hospital than has hitherto been the subject of historical investigation. If we consider these institutions within a wider temporal and geographical context, we can identify overlaps and similarities to other types of welfare provisions that existed in this period.

The Hessian welfare policies seem to have commenced earlier than many other state system of care – perhaps providing proof for Jütte's statement regarding their 'uniqueness' at the time of their conception. The establishment of the 'common chests' (*Allgemeinen Almosenkasten*) in Kassel in 1526, for instance, pre-dated that in its neighbour, Frankfurt am Main, by five years.[8] Similarly, the *Landesspitäler* also preceded the seventeenth-century hospitals built in Germany by the Brothers of Charity. Wolff has suggested that the latter were the model for the first general hospitals as they took in the predominantly sick whereas most other hospitals were increasingly *Pfründner-Anstalten*, acting as little more than retirement homes for those who could afford to purchase places therein.[9] This thesis has revealed that this was not the case.

Notable (and arguably novel) features of Philipp the Magnanimous' 'vision' of the Hessian territorial hospitals included their rural emphasis, the length of stay of the patients, the division of the inmates within the hospitals, and the segregation of residents according to gender. Another key feature was the theoretical self-sufficiency of these institutions and their communal atmosphere.[10]

One of the main ways in which the *Landesspitäler* differed from contemporary provision is found within the admittance of incurables. These institutions were clearly regarded in the public mind as providing a service that could not necessarily be found elsewhere, even within Hesse. The regional 'uniqueness' of this provision appears to have lasted throughout the period under consideration in

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[7] Midelfort, 'Protestant'; Jütte, Poverty, p. 213.
[8] Anon, Kranken, p. 17.
[9] Wolff & Wolff, Geschichte, p.88.
[10] The economic aspect of hospital bureaucracy (particularly with regard to self-sufficiency) is currently an expanding area of medical historiography. Further comparative research is needed to ascertain how innovative the *Landesspitäler* were in this practice. See, for example, Sneider,

this thesis, as has been exemplified by a 1744 petition to admit Carl Henrich Mathaii into *Closter* Haina.[11] In urban areas, the chronically ill were normally excluded from the main hospital, residing instead in specialist institutions. Thus, the new Viennese *Hofspital* of 1551 specifically excluded the unworthy poor, those suffering from pestilence, leprosy, syphilis (*Frantzosen*), and contagious diseases. It also barred those persons who were 'without reason' (*unsinnig*).[12] Whether the isolated rural location of Haina and Merxhausen can provide some form of explanation for its emphasis upon incurability is questionable. With the possible exception of some madness cases, geography seems unlikely to have been a decisive factor. In the incidences of mental illness, the long-term care offered to these inmates and the provision that these hospitals had to care for these types of illness were stressed – particularly if the invalid needed restraining.

The emphasis that the *Landesspitäler* placed upon chronic illnesses makes them comparable in outlook to the *Incurabili* hospitals of Italy and to the *Hôpitaux Généraux* in France. Katharine Park has charted the rise, beginning in the fifteenth-century of 'a preoccupation on the part of city authorities and charitable associations with chronic illness among the poor'. This is reflected in the establishment of large specialised hospitals for the incurably sick, some of which were general institutions while others catered for particular groups – the blind, syphilitics, epileptics and the insane. At the time of its establishment in 1678, the Montpellier Hôpital Général was envisaged 'to harbour both the 'impotent poor' or *invalides* – the aged, the infirm, the defenseless, - and also the able-bodied pauper, the beggar, the work-shy and the vagrant'.[13] These latter groups were barred from the *Landesspitäler*.

The Hessian territorial hospitals differed from the Italian models in the long duration of the patient's stay. Whereas in Italy, a patient could expect their stay to be several weeks or months in length, their Hessian counterpart could often

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Matthew, 'Hospital finance in sixteenth century Bologna'. Paper presented at the conference, 'Hospitals and Health: The Balance Sheet', Verona, 19 – 21 April, 2001.

[11] LWV, Bestand 13, Reskripte, 1745.

[12] Wendehorst, Juliusspital, p. 18; Nowotny, Geschichte, pp. 23 - 24.

[13] Jones, Charity, p. 61.

enjoy a residency of several years – stays of several decades were also not uncommon.[14] This difference can no doubt be attributed to the differing understanding of 'incurable' between the two types of institution. Whereas the *Incurabili* hospitals cared for patients suffering from contagious diseases such as syphilis, the *Landesspitäler* catered for the chronic illnesses that were, in themselves, usually not life-threatening. The applicants' lives were endangered through their physical or mental conditions, but this usually arose through their inability to provide for themselves and the real likelihood that they would die of cold or starvation if they did not receive assistance. The *Landesspitäler* can thus be viewed as fulfilling the terms of the Leisnig Ordinance of 1523, which stated that 'assistance should be given to the poor, infirm, and aged 'out of Christian love, to the honour and praise of God, so that their lives and health may be preserved from further deterioration, enfeeblement, and foreshortening though lack of shelter, clothing, nourishment and care''.[15]

Patients suffering from cancers and infectious diseases represented the minority. The existence, in Merxhausen, in 1606, of a girl suffering from *Morbus Gallicus* (probably syphilis) was thus the exception rather than the rule.[16] Strictly speaking, therefore, the *Landesspitäler* cannot be classified as institutions that were 'aimed at the *pauvres malades* (paupers who were sick) rather than to *malades pauvres* (sick individuals who, incidentally, were poor)'.[17] While some persons appear to have entered the institutions simply on account of their poverty – a group regarding whom more research is required – the majority of persons were suffering from some form of 'sickness'. For the *Landesspitäler*, 'sickness' was understood in terms of incapacity and impotence – both physical and mental. A combination of incurable sickness, coupled with both poverty and the complete breakdown of all available care networks constituted the principle criteria upon which a person's admission rested.

[14] For Italy, see the discussion in Cavallo, 'Family'.
[15] Quoted in Grell, Ole Peter, 'The Protestant imperative of Christian care and neighbourly love', in Grell, Ole Peter & Cunningham, Andrew, Health Care and Poor Relief in Protestant Europe, London & New York, 1997, pp. 43 – 65, here p. 53.
[16] LWV, Bestand 17, Reskripte, 1606.
[17] Quote taken from Jones, Charitable, p. 2.

Nor can the territorial hospitals be viewed as examples of Foucault's 'great confinement'.[18] This thesis has argued that the popularity of the hospitals both belies the notion of enforcement and 'confinement' and also suggests that their foundation was a response to a genuine social need, for a section of the populace who had hitherto been forgotten in welfare schemes. Moreover, although work played an important role within the establishments, these places cannot be viewed as early examples of the *Zuchthäuser* that were to become prevalent in the late seventeenth and eighteenth centuries. Work was carried out according to a person's capabilities, and, I have argued, related more to notions of identity and communal spirit than to rehabilitation, profit and business. As illustrated, much of the work that was expected to be undertaken was deemed to have been sufficiently simple that a child would have been able to manage it. In addition, whereas Foucault's 'institutions of confinement' predominantly catered for young or middle-aged males, the clientele of Haina and Merxhausen was very different and their physical capabilities suggest concerns that are wholly other than those in the hospitals studied by Foucault.[19]

Further evidence to refute a Foucauldian interpretation relates to the inmates' movements both inside and outside the institutions. More research relating to misdemeanours is required to gain a full picture of the situation. It appears however, that the reality of the situation was more lenient than the ordinances' conduct regulations would suggest. Certain individuals seem to have been a constant source of complaint for a considerable period of time and yet remained in the hospital. Other persons appear to have been in and out of these institutions on several occasions – both because they left 'illegally' or because they considered themselves cured, but made provision to return if their condition worsened again. Such occurrences are evident from the outset. In 1576, Johann Adeans from Marburg re-applied (once again) to be taken into Haina. Described as having been an inmate in the hospital upon several occasions, Johann was listed as suffering from mental problems.[20] Whether the potential danger that he

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[18] Foucault, Madness, p. 61. For a critique of these views, see among others, Dinges, 'Reception', pp. 181 – 212.

[19] See also the comments in Jones, Charity, p. 56. Compare to the findings of Martz, Linda, Poverty and Welfare in Habsburg Spain, Cambridge, 1983, pp. 210 – 211.

[2] LWV, Bestand 13, Reskripte, 1576.

posed to society was the principle reason for the tolerance and leniency with which his behaviour seems to have been taken is debatable. In comparison, the 1577 petition of an unnamed youth provides evidence of a former inmate who had left the hospital as he had believed himself to be cured, only to be plagued once more with his former illness. (He had problems with his thigh.)[21] The 1706 Haina account clearly mentions men who are '*absens*'. A number of these persons are stated as cured, and it is unclear whether or not these places have been kept vacant for them, should they need to return. Given the popularity of the hospitals, this seems unlikely. It may be that the individuals concerned were working for the hospital elsewhere (i.e. outside the institution's grounds) at the time that the lists were drawn up. Without further research, such answers can only be speculation.

II. Medical Practice in the Territorial Hospitals.

The role of medicine within the *Landesspitäler* represents another divergence from Foucault's model. In comparison to the imposed 'medicalisation' of the eighteenth-century hospital, the visits of the physicians to Haina and Merxhausen were rare. It also appears that some of the more able-bodied *Hospitaliten* assisted in the care of some of their brethren, even though they (the carers) were suffering from an 'incurable' condition themselves. As alluded to in Chapter Six, I believe that a different (and hierarchical) understanding of chronic illness existed among the sick inmates themselves. This is a topic that has hitherto be ignored in historical study, and it is one that requires further comparative research.

The origin of the territorial hospitals was not 'medical in its purpose' in the same way in which modern institutions are today. Nor indeed, did the patients hold the specific clinical interest that was a feature of the later eighteenth century teaching hospitals.[22] They also differed from the treatment offered to syphilitics in the *Blatternhäuser*, establishments which Jütte has described as the 'only charitable institution[s] providing full-fledged medical care before the late

[21] Ibid, 1577.
[22] For a brief summary, see Risse, Mending, pp. 217 – 246.

eighteenth century.'[23] The Hessian *Landesspitäler* were, instead, founded to offer long-term care to the chronically ill. Nevertheless, medicine also had to play a role from the outset – even if it were merely a case of managing an individual's pre-existing condition or of treating illnesses and injuries that occurred during their stay in the hospitals.

In terms of medical provision, Haina and Merxhausen are difficult to define. On the one hand, the institutions offered a much greater level of treatment than Erik Midelfort had supposed. Some patients were cured as a result of care that they received within the hospitals, and the belief that a recovery could be affected (and indeed that the treatment was due to them) is evident from the wide range of surviving documentation, some of which has been referred to in this thesis. Further statistical investigation is required to assess what proportion of inmates were 'cured'. (The sporadic nature of surviving accounts prior to the eighteenth-century may prohibit this work.) Simultaneously however, the incurable nature of the applicants' ailments is stressed throughout the petitions. Theoretically, these institutions could be viewed as antechambers to death. The fact that the majority of patients had lived in the hospital for many years (sometimes even decades) before they died, serves to negate this image however. This is a crucial area in which the *Landesspitäler* represent a novel form of institution that has been missing from early modern historiography.

Clearly these are not hospitals on the Florentine, Santa Maria Nuova model. Whether the relative infrequency of the doctor's visits – which occurred at least quarterly – can be taken as an indication of a lack of medical interest is debatable, but I would argue, incorrect. This is particularly true when one considers the important role played by the surgeons within the hospitals. Whether the difference in medical provision within the territorial hospitals related to the nature of rural medical provision is an issue that requires further study. (A wider investigation into rural and statewide medical services within Hesse is similarly necessary to provide further contextualisation and comparison for the arguments propounded within this thesis.) It seems more likely, however,

[23] Ibid, p. 115.

that the greater presence of surgeons as opposed to physicians relates more closely to the types of ailments and illnesses that the hospital catered for.

Haina and Merxhausen can perhaps be viewed as an extension of the situation in urban areas such as Zurich, as exemplified by the work of Aline Steinbrecher. She has charted the life cycle of a select number of mentally ill patients and has revealed that many of them spent their lives in and out of the hospitals, frequently 'cured' and then suffering relapses.[24] As has been shown, in Haina and Merxhausen too, it would seem that it was easier to be 'cured' of a mental illness than a physical one – probably because of the issue of 'seeing' and *'Augenschein'* that I have detailed in Chapter Three. In comparison to Zurich, Haina and Merxhausen provided a continual care network. Some patients were 'cured' of certain conditions and left the hospital under the proviso that they could return if necessary. As the 1706 Haina list has revealed, others were deemed 'cured, but were still considered generally unable to leave the hospital and fend for themselves. In this sense, the territorial hospitals can perhaps be viewed as a new category of hospital that amalgamated many different policies.

III. The Place of the Patient within Hospital History.

An overarching theme of this thesis has been the examination of the self-experience of physical illness among the sick poor. Based on the perspective of the sick poor themselves', as reflected in the pauper petitions, a central theme of this study has been the motivation behind an individual's application to a territorial hospital. This has found its main expression in an assessment of the ways in which the invalid experienced and coped with their infirmities prior to hospitalisation - a concept that is usually ignored by historians of early modern medicine. This thesis has utilised the notion of self-help as defined by Martin Dinges: 'the ability of individuals to endure a period of poverty or distress beyond the short-term logic of the market economy without asking for assistance'.[25] Contrary to Dinges' stance, however, I have stressed the

[24] Steinbrecher, 'Blödigkeit'.
[25] Dinges, 'Self-Help', p. 113.

fundamental role played by begging in these self-help strategies. I have argued that, far from being placing this activity on a par with criminal activities – as Dinges seems to – the ailing poor viewed begging in terms of work.[26] They used their participation in this activity as evidence of their status as the 'worthy poor'.

A detailed reconstruction of the hospitalisation process and the self-experience of physical illness are topics that have hitherto been ignored by historical study. Research focusing upon the early modern period has been largely silent with regards to the specific ways in which a prospective patient viewed a hospital, and to the point in a sick person's life in which they would apply for admission into such an institution. Such a dearth of interest can be compared to the growing number of studies which relate to applications for poor relief and which concentrate upon the role of this aid within life-cycle strategies.[27] No thorough study relating to medicine and hospitalisation from the sixteenth- to the early eighteenth-centuries has previously existed.[28] This study has endeavoured to rectify this bias.

Chapters on family care, old age, and work have evaluated the poor's experience of illness prior to hospitalisation. An overarching theme of this study has focused upon the misconception of the poor as passive recipients of relief. The perceptions of the inmates regarding the place of these institutions within their 'illness experience' and life-cycle strategy have been compared to the motivations both of the founder and of those in charge of the day-to-day running of the establishments. Space constraints within the thesis prevented a broader discussion concerning other dominant themes that can be found within the petitions. Such topics – including the role of accidents and misfortune, the military patient, and the gendered experience of illness – require future consideration.[29]

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[26] Ibid, p. 124, footnote 3.
[27] See especially, Hitchcock et al (ed.), Chronicling; Snell, Annals.
[28] One possible exception is Hudson, Ex-Servicemen.
[29] Regarding the gendered experience of illness, see Gray, Louise, 'The "Secret" Body Outside the Womb? Women's Experience of Physical Illness in Early Modern Germany'. Paper presented at the 'Secret Bodies: Medical Knowledge and Early Modern Women' conference, held at the University of Warwick, July 2000.

One of the most striking points regarding these petitions concerns the petitioners' attitudes with respect to their physical condition. Many of the reports stress as the overwhelming reason for appealing for entry into the hospital, not one's physical frailties, but one's current inability to feed oneself. Evidently, the former had contributed to the latter, but it is, to my mind, of great significance that the applicants had coped for so many years under physical conditions that most of us would assume to be grounds for hospitalisation. To put it simply, if one merely looked at hospital lists of patients that give details such as name and affliction, one would arrive at a wholly different conclusion as to which illnesses would render people incapable of fending for themselves; or, more to the point, at which stage the medical condition would lead a person to seek hospitalisation. It is undoubtedly true that physical conditions such as lameness and blindness would frequently prevent people from working in a traditional sense, but the evidence in the petitions reveal that most of the applicants laboured with these afflictions for many years before seeking help.

Rather than viewing the poor as statistical lists of names, or as a category for poor relief and charitable assistance, this thesis has explored the experience of poverty and chronic illness within the localised setting of Hesse as it related to those patients who applied for admission to the territorial hospitals of Haina and Merxhausen. Medical historiography has previously focused upon the motivations of benefactors in establishing a hospital but has neglected to investigate the role that the recipients of this care – the sick – envisaged the institutions would play in their lives. The second part of this thesis can be, therefore, be summarised as a form of *Alltagsgeschichte* relating to chronic illness, poverty and institutions within the context a specific and localised setting. This enquiry wished to move away from the tendency to view both the 'poor' as a mass category, and the 'sick poor' as one of a list of medical conditions, and to restore to them a voice which would offer more detail regarding the reality of both of these states of being. Rather than utilise the Hessian petitions to provide quantitative data regarding the inmates of Haina and Merxhausen, I have looked 'individually at these ancestors of ours before they disappeared by the thousands into the computer, only to appear anonymously

again at the end as statistical averages.'[30] Too much emphasis to date has been afforded to administrative histories of hospitals that have categorised the institutions within an historical framework. Too often, the sick poor have only appeared as numbers on a statistical table. This thesis has gone some way to redress this balance, by concentrating upon their 'voices' and has thereby broadened our understanding of 'patient history'.

The primary focus of this study has been upon the experience of chronic illness among the labouring poor. It has considered how individuals coped with these ailments prior to submitting applications for hospitalisation. It is hoped that this thesis has gone some way to dealing with one of the areas that are still largely neglected in medical history – 'to probe the personal and collective meanings of sickness, of suffering and recovery, probing how 'illness experiences' were integrated within the larger meanings of life, from the cradle to the grave.'[31]

[30] Imhof, Lost, pp. 2 – 3.
[31] Porter, Roy, 'Introduction', in Idem (ed.), Patients, p. 5.

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